for each of the three months immediately preceding the due date of the amount to which the application relates. The application, with supporting documents, must be filed on or before the date prescribed for payment of the amount with respect to which the extension is desired with the internal revenue officer to whom the tax is to be paid. The application will be examined, and within 30 days, if possible, will be denied, granted, or tentatively granted subject to certain conditions of which the taxpayer will be notified. If an additional extension is desired, the request therefor must be made on or before the expiration of the period for which the prior extension is granted.

(d) *Payment pursuant to extension.* If an extension of time for payment is granted, the amount the time for payment of which is so extended shall be paid on or before the expiration of the period of the extension without the necessity of notice and demand. The granting of an extension of the time for payment of the tax or deficiency does not relieve the taxpayer from liability for the payment of interest thereon during the period of the extension. See section 6601 and §301.6601–1 of this chapter (Regulations on Procedure and Administration).

§53.6165–1 Bonds where time to pay tax or deficiency has been extended.

If an extension of time for payment of tax or deficiency is granted under section 6161, the district director or the director of the service center may, if he deems it necessary, require a bond for the payment of the amount in respect of which the extension is granted in accordance with the terms of the extension. However, such bond shall not exceed double the amount with respect to which the extension is granted. For provisions relating to form of bonds, see the regulations under section 7101 contained in part 301 of this chapter (Regulations on Procedure and Administration).

§53.6601–1 Interest on underpayment, nonpayment, or extensions of time for payment, of tax.

For regulations concerning interest on underpayment, nonpayment, or extensions of time for payment of tax, see §301.6601–1 of this chapter (Regulations on Procedure and Administration).

§53.6651–1 Failure to file tax return or to pay tax.

(a) *General rules.* For general rules relating to the failure to file tax return or to pay tax, see the regulations under section 6651 contained in part 301 of this chapter (Regulations on Procedure and Administration).

(b) *Special rule where foundation files return.* (1) Except as provided in paragraph (b)(2) of this section, in the case of tax imposed by section 4941(a)(1) on any disqualified person, reasonable cause shall be presumed, for purposes of section 6651(a)(1), where the private foundation or trust described in section 4947(a)(2) files a return in good faith and such return indicates no tax liability with respect to such tax on the part of such disqualified person.

(2) Paragraph (b)(1) of this section shall not apply where the disqualified person knew of facts which, if known by the foundation, would have precluded the foundation from making the return, as filed, in good faith.

§53.7101–1 Form of bonds.

For provisions relating to form of bonds, see the regulations under section 7101 contained in part 301 of this chapter (Regulations on Procedure and Administration).

PART 54—PENSION EXCISE TAXES

Sec.

AUTHORITY: 26 U.S.C. 7805, unless otherwise noted;

Section 54.4981A–1T is also issued under 26 U.S.C. 4981A.

Section 54.4980B–1 also issued under 26 U.S.C. 4980B.

Section 54.4980B–2 also issued under 26 U.S.C. 4980B.

Section 54.4980B–3 also issued under 26 U.S.C. 4980B.

Section 54.4980B–4 also issued under 26 U.S.C. 4980B.

Section 54.4980B–5 also issued under 26 U.S.C. 4980B.

Section 54.4980B–6 also issued under 26 U.S.C. 4980B.

Section 54.4980B–7 also issued under 26 U.S.C. 4980B.

Section 54.4980B–8 also issued under 26 U.S.C. 4980B.

Section 54.4980B–9 also issued under 26 U.S.C. 4980B.

Section 54.4980B–10 also issued under 26 U.S.C. 4980B.

Section 54.9801–1T also issued under 26 U.S.C. 9833.

Section 54.9801–2T also issued under 26 U.S.C. 9833.

Section 54.9801–3T also issued under 26 U.S.C. 9833.

Section 54.9801–4T also issued under 26 U.S.C. 9833.

Section 54.9801–5T also issued under 26 U.S.C. 9801(c)(4), 9801(e)(3), and 9833.

Section 54.9801–6T also issued under 26 U.S.C. 9833.

Section 54.9802–1T also issued under 26 U.S.C. 9833.

Section 54.9811–1T also issued under 26 U.S.C. 9833.

Section 54.9812–1T also issued under 26 U.S.C. 9833.

Section 54.9831–1T also issued under 26 U.S.C. 9833.

Section 54.9833–1T also issued under 26 U.S.C. 9833.

§ 54.4971–1 General rules relating to excise tax on failure to meet minimum funding standards.

(a)–(b) [Reserved]

(c) *Additional tax.* Section 4971(b) imposes an excise tax in any case in which an initial tax is imposed under section 4971(a) on an accumulated funding deficiency and the accumulated funding deficiency is not corrected within the taxable period (as defined in section 4971(c)(3)). The additional tax is 100 percent of the accumulated funding deficiency to the extent not corrected.

(d) [Reserved]

(e) *Definition of taxable period*—(1) *In general.* For purposes of any accumulated funding deficiency, the term

''taxable period'' means the period beginning with the end of the plan year in which there is an accumulated funding deficiency and ending on the earlier of:

(i) The date of mailing of a notice of deficiency under section 6212 with respect to the tax imposed by section 4971(a), or

(ii) The date on which the tax imposed by section 4971(a) is assessed.

(2) *Special rule.* Where a notice of deficiency referred to in paragraph (e)(1)(i) of this section is not mailed because a waiver of the restrictions on assessment and collection of a deficiency has been accepted or because the deficiency is paid, the date of filing of the waiver or the date of such payment, respectively, shall be treated as the end of the taxable period.

[T.D. 8084, 51 FR 16305, May 2, 1986]

§ 54.4972–1 Tax on excess contributions to plans benefiting self-employed individuals.

(a) *In general.* Section 4972 imposes a tax of 6 percent on the amount of the excess contributions (as defined in section 4972 (b) and (c) of this section) under certain qualified plans (as defined in paragraph (b) of this section) for each taxable year beginning after December 31, 1975, of the employer who maintains such plan. Partnerships and sole proprietors are to report this tax by filing Form 5330 (or other designated form) and the tax is to be paid annually at the time prescribed for filing such return (determined without regard to any extension of time for filing).

(b) *Employers to whom section applies.* The tax under section 4972 is imposed on employers who maintain a qualified plan during their taxable year. For this purpose, the term *qualified plan* means a pension or profit-sharing plan which includes a trust described in section 401(a), an annuity plan described in section 403(a), or a bond purchase plan described in section 405(a). In addition to being a qualified plan, the plan must provide contributions or benefits for employees some or all of whom are employees within the meaning of section 401(c)(1). For this purpose, the plan does not have to provide contributions or benefits for employees who are employees within the meaning of section 401(c)(1) during the taxable year; it is sufficient that the plan so provided in a prior taxable year.

(c) *Excess contributions*—(1) *In general.* For a taxable year of an employer for purposes of section 4972 and this section, the term ''excess contributions'' means:

(i) The amount (if any) by which the sum of:

(A) The amount (if any) determined under section 4972(b)(2) and paragraph (d) of this section, plus

(B) The amount (if any) determined under section 4972(b)(3) and paragraph (e) of this section, plus

(C) The amount (if any) determined under section 4972(b)(4) and paragraph (f) of this section, exceeds

(ii) The amount (if any) of any correcting distributions (as defined in section 4972(b)(5) and paragraph (g) of this section) made in all prior taxable years beginning after December 31, 1975.

(2) *Contributions allocable to insurance.* For purposes of section 4972(b) and this section, the amount of any contribution made under the plan which is allocable to the purchase of life, accident, health, or other insurance is not taken into account. The amount of any contribution which is allocable to the cost of insurance protection is determined in accordance with the provisions of paragraph (g) of § 1.404(e)–1A and paragraph (b) of § 1.72–16.

(d) *Contributions by owner-employees*—(1) *General rule.* In the case of a plan which provides contributions or benefits for employees some or all of whom are owner-employees, within the meaning of section 401(c)(3), the amount determined under section 4972(b)(2) and this paragraph for the employer's taxable year is the amount computed separately with respect to each owner-employee equal to the sum of:

(i) The excess (if any) of

(A) The amount contributed under the plan by each owner-employee as an employee (that is, each owner-employee's contributions within the meaning of section 401(c)(5)(B)) for such taxable year of the employer, over

(B) The amount permitted under section 4972(c) and paragraph (h) of this section to be contributed by each

owner-employee as an employee for such taxable year of the employer, and

(ii) The amount determined under section 4972(b)(2) and this paragraph for the immediately preceding taxable year of the employer, reduced by the excess (if any) of the amount described in subdivision (1)(B) of this subparagraph over the amount described in subdivision (1)(A) of this subparagraph for such taxable year of the employer.

(2) *Rollover amounts.* The provisions of section 4972 (c) and paragraph (d) of this section are not applicable to amounts contributed on behalf of an owner-employee in a rollover contribution described in section 402(a)(5), 403(a)(4), 408(d)(3), or 409(b)(3)(C).

(3) *Examples.* The provisions of this paragraph may be illustrated by the following examples:

Example (1). (i) A and B are the only owner-employees covered under the X Employees' Trust. The X Partnership, the X Trust, and the X Plan all use the calendar year as their annual accounting period, at all relevant times. The amount determined under section 4972(b)(2) for 1975 is 0 because this section does not apply to contributions made for taxable years beginning before January 1, 1976. In calendar year 1976, A contributes $2,500 and B contributes $2,500 to the trust. The amount permitted to be contributed to the trust for 1976 with respect to A as an employee is $1,800 and with respect to B as an employee is $2,200.

(ii) The amount determined under this paragraph for 1976 with respect to A is $700, computed as follows: the sum of the excess of the amount contributed by A ($2,500) over the amount permitted to be contributed by A ($1,800), and the amount determined under this paragraph for A in 1975 (0).

(iii) The amount determined under this paragraph for 1976 with respect to B is $300, computed as follows: the sum of the excess of the amount contributed by B ($2,500) over the amount permitted to be contributed by B ($2,200), and the amount determined under this paragraph for B in 1975 (0).

(iv) The amount determined under section 4972(b)(2) and this paragraph for 1976 with respect to the employer, X Partnership, is $1,000, the sum of the amounts determined separately under this paragraph with respect to A ($700) and B ($300). The tax under section 4972 for 1976 on the X Partnership (assuming that no other events affecting the determination of the tax under section 4972 occur) is 6 percent of $1,000 or $60.

Example (2). (i) Assume the facts stated in Example (1). In calendar year 1977, A contributes $1,500 and B contributes $2,300 to the trust. Assume that the amount permitted to be contributed to the trust for 1977, under section 4972(c) for A and B is $2,500 each.

(ii) The amount determined under this paragraph for 1977 with respect to A is 0, computed as follows: the sum of 0 (the excess of the amount contributed by A ($1,500) over the amount permitted to be contributed ($2,500)) and $700, the amount determined under this paragraph for A in 1976, reduced by $1,000 (the amount permitted to be contributed by A ($2,500) over the amount contributed by A ($1,500)).

(iii) The amount determined under this paragraph for 1977 with respect to B is $100, computed as follows: the sum of 0 (the excess of the amount contributed by B ($2,300) over the amount permitted to be contributed ($2,500)) and $300, the amount determined under this paragraph for B in 1976, reduced by $200 (the amount permitted to be contributed ($2,500) by B over the amount contributed by B ($2,300)).

(iv) The amount determined under section 4972(b) and this paragraph for 1977 with respect to the employer, X Partnership, is $100, the sum of the amounts determined separately under this paragraph with respect to A ($0) and B ($100). The tax imposed under section 4972 for 1977 on the X Partnership (assuming that no other events affecting the determination of the tax under section 4972 occur) is 6 percent of $100, or $6.

(e) *Defined benefit plans*—(1) *General rule.* In the case of a defined benefit plan (as defined in section 414(j)), the amount determined under section 4972(b)(3) and this paragraph for the taxable year of the employer is the amount contributed under the plan by the employer during the taxable year plus the amounts, if any, contributed by the employer during any prior taxable year beginning after December 31, 1975, if:

(i) As of the close of the taxable year, the full funding limitation of the plan (determined under section 412(c)(7) and the regulations thereunder) is zero, and

(ii) Such amounts contributed have not been deductible by the employer for the taxable year or for any prior taxable year beginning after December 31, 1975.

See section 404 and the regulations thereunder for the determination of the amount deductible by the employer for the taxable year. If the amounts contributed by the employer exceed the amounts which have been deductible, the amount determined under this paragraph shall not exceed the amounts which have not been deductible. For purposes of this paragraph,

the determination of both the amounts contributed and the amounts deductible by the employer for any relevant taxable year includes amounts contributed and deductible on behalf of any employee covered under the plan, including common-law employees and other self-employed individuals who are not owner-employees in addition to owner-employees. The determination of whether the full funding limitation is zero shall be made taking into account all the plan assets unreduced by any deduction carryover under section 404(a)(1)(D). The determination of whether the full funding limitation is zero as of the close of the employer's taxable year shall be made with respect to the plan year ending with or within the employer's taxable year. Consequently, if an employer whose taxable year is the calendar year establishes and maintains a defined benefit plan whose plan year begins on July 1 and ends on June 30, the full funding limitation for that plan will be determined with respect to the plan year ending on June 30 within the calendar taxable year including that June 30.

(2) *Illustration.* The provisions of this paragraph may be illustrated by the following example:

Example. (i) X Partnership (''X'') adopts the Y Defined Benefit Plan (''Y Plan'') on January 1, 1977. The taxable year of X is the calendar year. The Y Plan also has a calendar plan year. For 1977, $25,000 is contributed to the Y Plan by X. Assume that for 1977, (1) only $10,000 is deductible by X for 1977 under section 404 and (2) the full funding limitation of the Y Plan (determined under section 412(c)(7)) on December 31, 1977, is greater than zero. For 1978, X makes no additional contributions to the Y Plan. Assume that for 1978, (1) no amount is deductible by X under section 404 and (2) the full funding limitation of the Y Plan (determined under section 412(c)(7)) on December 31, 1978, is zero. The amount determined under section 4972(b)(3) and this paragraph for the 1978 taxable year is $15,000, computed as follows: the difference between (A) the sum of the amounts contributed by X for taxable year 1978 (0), and the amounts contributed by X for taxable year 1977 ($25,000) and (B) the sum of the amount deductible for taxable year 1978 (0) and the amount deductible for taxable year 1977 ($10,000). The tax imposed under section 4972 for 1978 on X (assuming that no other events affecting the determination of the tax under section 4972 occur) is 6 percent of $15,000 or $900.

(ii) For 1979, X makes no additional contributions to the Y Plan. Assume that for 1979, (1) the full funding limitation of the Y Plan determined under section 412(c)(7) is greater than zero. Assume further that $10,000 of the amounts contributed for 1977 is deductible by X for 1979 under section 404. There is no amount determined under section 4972(b)(3) and this paragraph for 1979 because the condition described in subparagraph (1)(i) of this paragraph is not satisfied.

(iii) For 1980, X makes no additional contributions to the Y Plan. Assume that for 1980, (1) no amount is deductible under section 404 and (2) the full funding limitation of the Y Plan (determined under section 412(c)(7)) on December 31, 1980, is zero. The amount determined under section 4972(b)(3) and this paragraph for the 1980 taxable year is $5,000, computed as follows: the difference between (A) $25,000, the sum of the amounts contributed by X for taxable years 1980 (0), 1979 (0), 1978 (0), and 1977 ($25,000) and (B) $20,000, the sum of the amounts deductible for taxable years 1980 (0), 1979 ($10,000), 1978 (0), and 1977 ($10,000). The tax imposed under section 4972 for 1980 on X (assuming that no other events affecting the determination of the tax under section 4972 occur) is 6 percent of $5,000, or $300.

(f) *Defined contribution plans*—(1) *General rule.* In the case of a defined contribution plan (as defined in section 414(i)), the amount determined under section 4972(b)(4) and this paragraph for the taxable year of the employer is equal to the portion of the amounts contributed under the plan by the employer during the taxable year plus the amounts contributed by the employer during any prior taxable year beginning after December 31, 1975, which has not been deductible by the employer for the taxable year or for any such prior taxable year. For purposes of this paragraph, the determination of both the amounts contributed and the amounts deductible by the employer for any relevant taxable year includes amounts contributed and deductible on behalf of any employee covered under the plan, including common-law employees and other self-employed individuals who are not owner-employees in addition to owner-employees.

(2) *Illustration.* The provisions of this paragraph may be illustrated by the following example:

Example. (i) The X Partnership (''X'') adopts the Z Defined Contribution Plan and Trust (''Z Plan'') on January 1, 1976. X's taxable year and the plan year of Z Plan are both calendar years. For 1976, X contributes

$40,000, of which $30,000 is deductible under section 404 for taxable year 1976. The amount determined under section 4972(b)(4) and this paragraph for 1976 is $10,000 (the difference between (A) $40,000, the amount contributed by X for taxable year 1976 and (B) $30,000, the amount deductible for taxable year 1976).

(ii) For 1977, X contributes $25,000, and the amounts deductible by X under section 404 for taxable year 1977 is $30,000 ($5,000 for the contribution carryover from 1976 and $25,000 with respect to the 1977 contribution). The amount determined under section 4972(b)(4) and this paragraph for 1977 is $5,000, computed as follows: the difference between (A) $65,000, the sum of the amounts contributed by X for taxable year 1976 ($40,000) and the amounts contributed by X for taxable year 1977 ($25,000), and (B) $60,000, the sum of the amounts deductible for taxable year 1976 ($30,000) and the amounts deductible for taxable year 1977 ($30,000).

(g) *Correcting distribution*—(1) *General rule.* For purposes of section 4972(b) and this paragraph, the term ''correcting distribution'' means, for the taxable year of the employer, the sum of:

(i) In the case of a contribution made as an employee by an owner-employee, within the meaning of section 401(c)(3), to a defined benefit or defined contribution plan, the amount, or any part thereof, determined under section 4972(b)(2) and paragraph (d) of this section which is distributed to the owner-employee who contributed such amount to the plan;

(ii) In the case of a defined benefit plan, the amount, or any part thereof, determined under section 4972(b)(3) and paragraph (e) of this section which is distributed from the plan to the employer, and

(iii) In the case of a defined contribution plan, the amount, or any part thereof, determined under section 4972(b)(4) and paragraph (f) of this section which is distributed to (A) the employer or (B) to the employee for whom such amount was contributed.

If, for any employer taxable year in which a defined contribution plan is maintained, there is a correcting distribution to an employee which could be from amounts described in subparagraph (1)(i) and (iii) of this paragraph for such employee, then such correcting distribution shall be deemed to be made first from amounts described in such subparagraph (1)(i) and then from amounts described in such subparagraph (1)(iii) for purposes of this section and section 72. For the income tax treatment of such distributions to employees, see section 72 and the regulations thereunder. Any such distributions to employees shall not be subject to the tax imposed by section 4975 nor result in the defined contribution plan failing to satisfy the exclusive benefit requirement of section 401(a), solely by reason of being a correcting distribution within the meaning of this paragraph. If, for any employer taxable year in which a defined benefit, or defined contribution plan is maintained, there is a correcting distribution described in subparagraph (1)(ii) or (iii) of this paragraph to the employer maintaining the plan, such distribution shall not be subject to the tax imposed by section 4975 nor result in the plan's failing to satisfy the exclusive benefit or the definitely determinable requirements under section 401(a). If, for any employer taxable year in which a money purchase pension plan is maintained, a correcting distribution described in subparagraph (1)(iii) of this paragraph is made to an employee who has not yet become eligible to receive retirement benefits under the plan, the qualification of the pension plan (and trust) under section 401(a) may be adversely affected. See §1.401–1(b)(1)(i). A correcting distribution described in subparagraph (1)(iii) of this paragraph to an owner-employee prior to age 59½ must be precluded under the plan. See section 401(d)(4)(B).

(2) *Illustration.* The provisions of this paragraph may be illustrated by the following example:

Example. (i) A and B are owner-employees who are over the age of 59½ and who are covered under the X Employees' Defined Contribution Plan and Profit-Sharing Trust (''Plan Y''). The X Partnership (''X'') and Plan Y are on calendar years. In calendar year 1976, A contributes $2,500 and B contributes $2,500 to Plan Y. The amount permitted to be contributed to Plan Y for 1976 with respect to A as an employee is $1,800 and with respect to B as an employee is $2,200. X contributes to Plan Y $5,000 on behalf of A and $5,000 on behalf of B. Of this amount, assume that $2,700 is deductible with respect to A and $3,300 is deductible with respect to B by X under section 404. The amount determined under section 4972(b)(2) and paragraph (d) of this section (the excess owner-employee contributions made by A and B to Plan Y) for

taxable year 1976 is $1,000, computed as follows: the sum of (A) for A, $700, the difference between his own contributions ($2,500) and the amount permitted to be contributed by A ($1,800) and (B) for B, $300, the difference between his own contributions ($2,500) and the amount permitted to be contributed by B ($2,200). The amount determined under section 4972(b)(4) and paragraph (f) of this section (the excess contributions made by X to Plan Y) for taxable year 1976 is $4,000, computed as follows: the sum of (A) by X for A, $2,300, the difference between contributions by X ($5,000) and the amount deductible by X for A ($2,700) and (B) by X for B, $1,700, the difference between contributions by X for B ($5,000) and the amount deductible by X for B ($3,300). During 1976, there is no correcting distribution, within the meaning of section 4972 and this paragraph, because there are no distributions to A, B, or X.

(ii) Assume that, for taxable year 1977, the amounts determined under sections 4972(b)(2) and 4972(b)(4) remain the same as for taxable year 1976, that is, $1,000 ($700 for A and $300 for B) and $4,000 ($2,300 by X for A and $1,700 by X for B), respectively. Assume further that, in 1977, Plan Y distributes $3,000 to A and $1,000 to B. The amount determined under section 4972(b)(5) and this paragraph (the correcting distribution for Plan Y) for taxable year 1977 is $4,000, computed and attributed as follows: the sum of (A) $3,000 with respect to A, the amount of the distribution to A applied first to A's $700 amount described in subparagraph (1)(i) of this paragraph and next to A's $2,300 amount described in subparagraph (1)(iii) of this paragraph and (B) $1,000 with respect to B, the amount of the distribution to B applied first to B's $300 amount described in subparagraph (1)(i) of this paragraph and next to B's $1,700 amount described in subparagraph (1)(iii) of this paragraph. For purposes of computing the excess contributions for taxable year 1977, the correcting distribution of $4,000 would not be taken into account because only correcting distributions for prior year are considered. However, for taxable year 1978 the correcting distribution of $4,000 would be taken into account.

(iii) Assume that, for taxable year 1978, there are no additional amounts determined under sections 4972(b)(2) and 4972(b)(4) and that Plan Y distributes $900 to B. The amount determined under section 4972(b)(5) and this paragraph (the correcting distribution for Plan Y) for the 1978 taxable year is $900, computed and attributed as follows: the amount of the distribution to B, $900, applied to B's $1,000 amount described in subparagraph (1)(iii) of this paragraph. For purposes of computing the excess contributions for taxable year 1978, the correcting distribution of $900 would not be taken into account. However, for taxable year 1979, the correcting distribution of $900 would be taken into account.

(h) *Amount permitted to be contributed by owner-employee*—(1) *General rule.* Except as provided in subparagraph (2), for purposes of section 4972(b)(2) and paragraph (d), the amount permitted to be contributed under a plan by an owner-employee as an employee for any taxable year of the employer is the smallest of the following:

(i) $2,500;

(ii) 10 percent of the earned income (as defined in section 401(c)(2)) for such taxable year derived by the owner-employee from the trade or business with respect to which the plan is established, or

(iii) The amount of the contribution which would be contributed by the owner-employee (as an employee) if such contribution were made at the rate of contributions which is permitted to be made by employees who are not owner-employees during such taxable year.

(2) *Special rule.* In the case of a taxable year of the employer in which there are no employees other than owner-employees, the amount permitted to be contributed under a plan by an owner-employee (as an employee) is zero.

(i) *Special rules and cross references*—(1) *Time of contributions.* For purposes of this section, time of employer contributions made with respect to any taxable year shall take into account the rules specified in section 404(a)(6), relating to time when contributions deemed made.

(2) *Disallowance of deduction.* For disallowance of deduction for taxes paid under this section, see section 275(a)(6).

(3) *Certain annuity contracts.* For a special rule relating to owner-employee contributions for premiums on annuity, etc. contracts, see § 1.401(e)4(a)

(4) *Disqualification for excess contributions.* For plan qualification requirements relating to excess contributions, see section 401(d)(5).

[T.D. 7759, 46 FR 6932, Jan. 22, 1981]

§ 54.4974–1 Excise tax on accumulations in individual retirement accounts or annuities.

(a) *General rule.* A tax equal to 50 percent of the amount by which the minimum amount required to be distributed from an individual retirement account or annuity described in section 408 during the taxable year of the payee under paragraph (b) of this section exceeds the amount actually distributed during the taxable year is imposed by section 4974 on the payee.

(b) *Minimum amount required to be distributed.* For purposes of this section, the minimum amount required to be distributed is the amount required under §1.408–2(b)(6)(v) to be distributed in the taxable year described in paragraph (a) of this section.

(c) *Examples.* The application of this section may be illustrated by the following examples.

Example (1). In 1975, the minimum amount required to be distributed under §1.408–2(b)(6)(v) to A under his individual retirement account is $100. Only $60 is actually distributed to A in 1975. Under section 4974, A would have an excise tax liability of $20 [50% of ($100—$60)].

Example (2). Although no distribution is required under §1.408–2(b)(6)(v) to be made in 1986, H, a married individual born on February 1, 1921, who has established and maintained an individual retirement account decides to begin receiving distributions from the account beginning in 1986. H's wife, W, was born on March 6, 1921. H and W are calendar year taxpayers. H decides to receive his interest in the account over the joint life and last survivor expectancy of himself and his wife. On January 1, 1986, the balance in H's account is $10,000; H and W, based on their nearest birthdates, are 65; and the joint life and last survivor expectancy of H and his wife is 22.0 years (see Table II of §1.72–9). His annual payments during the following years (none of which were required) were determined by dividing the balance in the account on the first day of each year by the joint life and last survivor expectancy reduced by the number of whole years elapsed since the distributions were to commence.

Date	Life expectancy minus whole years elapsed	Account balance at beginning of each year	Annual payment
Jan. 1, 1986	22.0	$10,000	$455
Jan. 1, 1987	21.0	10,118	482
Jan. 1, 1988	20.0	10,214	511
Jan. 1, 1989	19.0	10,285	541
Jan. 1, 1990	18.0	10,329	574
Jan. 1, 1991	17.0	10,340	608

For 1986, 1987, 1989, and 1990, the amount required to be distributed under §1.408–2(b)(6)(v) is zero. Thus, H would have no excise tax liability under section 4974 for these years. In 1991, the year H attains age 70½, the amount required to be distributed from the account under §1.408–2(b)(6)(v) is $565, determined by dividing $10,340 (the account balance as of January 1, 1991) by 18.8 years (the joint life and last survivor expectancy of H and W, assuming they are both still living, as of January 1, 1991). If W should die after December 31, 1990, the joint life and last survivor expectancy determined on January 1, 1991 (18.3 years) would not be redetermined. Because the amount distributed from the account in 1991 ($608) exceeds the amount required to be distributed from the account in 1991 ($565), H has no excise tax liability under section 4974 for 1991.

Example (3). Assume the same facts as in example (2) except that W dies in 1988. For 1988, 1989, and 1990, the amount required to be distributed under §1.408–2(b)(6)(v) is zero. Thus, H would have no excise tax liability under section 4974 for these years. In 1991, the amount required to be distributed under §1.408–2(b)(6)(v) is $855, determined by dividing $10,340 (the account balance as of January 1, 1991) by 12.1 years (the life expectancy of H as of January 1, 1991). Because the amount distributed from the account in 1991 ($608) is less than the amount required to be distributed from the account in 1991 ($855), H has an excise tax liability of $123.50 under section 4974 for 1991 [50% of ($855—$608)].

[T.D. 7714, 45 FR 52799, Aug. 8, 1980]

§ 54.4975–1 General rules relating to excise tax on prohibited transactions.

(a) *Scope.* This section provides general rules for the imposition of the excise taxes on prohibited transactions.

(b) *Initial tax.* Section 4975(a) imposes an initial tax on each prohibited transaction. The initial tax is 5 percent of the amount involved with respect to the prohibited transaction for each year (or part thereof) in the taxable period.

(c) *Additional tax.* Section 4975(b) imposes an excise tax in any case in which an initial tax is imposed under

section 4975(a) on a prohibited transaction and the prohibited transaction is not corrected within the taxable period (as defined in paragraph (d) of this section). The additional tax is 100 percent of the amount involved with respect to the prohibited transaction.

(d) *Taxable period*—(1) *In general.* For purposes of any prohibited transaction, the term ''taxable period'' means the period beginning with the date on which the prohibited transaction occurs and ending on the earliest of:

(i) The date of mailing of a notice of deficiency under section 6212 with respect to the tax imposed by section 4975(a);

(ii) The date on which correction of the prohibited transaction is completed; or

(iii) The date on which the tax imposed by section 4975(a) is assessed.

(2) *Special rule.* Where a notice of deficiency referred to in paragraph (d)(1)(i) of this section is not mailed because a waiver of the restrictions on assessment and collection of a deficiency has been accepted or because the deficiency is paid, the date of filing of the waiver or the date of such payment, respectively, shall be treated as the end of the taxable period.

[T.D. 8084, 51 FR 16305, May 2, 1986]

§ 54.4975–6 Statutory exemptions for office space or services and certain transactions involving financial institutions.

(a) *Exemption for office space or services*—(1) *In general.* Section 4975(d)(2) exempts from the excise taxes imposed by section 4975 payment by a plan to a disqualified person, including a fiduciary, for office space or any service (or a combination of services), if (i) such office space or service is necessary for the establishment or operation of the plan; (ii) such office space or service is furnished under a contract or arrangement which is reasonable; and (iii) no more than reasonable compensation is paid for such office space or service. However, section 4975(d)(2) does not contain an exemption for acts described in section 4975(c)(1)(E) (relating to fiduciaries dealing with the income or assets of plans in their own interest or for their own account) or acts described in section 4975(c)(1)(F) (relating to fiduciaries receiving consideration for their own personal account from any party dealing with a plan in connection with a transaction involving the income or assets of the plan). Such acts are separate transactions not described in section 4975(d)(2). See §§ 54.4975–6(a)(5) and 54.4975–6(a)(6) for guidance as to whether transactions relating to the furnishing of office space or services by fiduciaries to plans involve acts described in section 4975(c)(1)(E).

Section 4975(d)(2) does not contain an exemption from other provisions of the Code, such as section 401, or other provisions of law which may impose requirements or restrictions relating to the transactions which are exempt under section 4975(d)(2). See, for example, the general fiduciary responsibility provisions of section 404 of the Employee Retirement Income Security Act of 1974 (the Act) (88 Stat. 877). The provisions of section 4975(d)(2) are further limited by the flush language at the end of section 4975(d) (relating to transactions with owner-employees and related persons).

(2) *Necessary service.* A service is necessary for the establishment or operation of a plan within the meaning of section 4975(d)(2) and § 54.4975–6(a)(1)(i) if the service is appropriate and helpful to the plan obtaining the service in carrying out the purposes for which the plan is established or maintained. A person providing such a service to a plan (or a person who is disqualified person solely by reason of a relationship to such a service provider described in section 4975(e)(2) (F), (G), (H), or (I)) may furnish goods which are necessary for the establishment or operation of the plan in the course of, and incidental to, the furnishing of such service to the plan.

(3) *Reasonable contract or arrangement.* No contract or arrangement is reasonable within the meaning of section 4975(d)(2) and § 54.4975–6(a)(1)(ii) if it does not permit termination by the plan without penalty to the plan on reasonably short notice under the circumstances to prevent the plan from becoming locked into an arrangement that has become disadvantageous. A long-term lease which may be terminated prior to its expiration (without

penalty to the plan) on reasonably short notice under the circumstances is not generally an unreasonable arrangement merely because of its long term. A provision in a contract or other arrangement which reasonably compensates the service provider or lessor for loss upon early termination of the contract, arrangement or lease is not a penalty. For example, a minimal fee in a service contract which is charged to allow recoupment of reasonable start-up costs is not a penalty.

Similarly, a provision in a lease for a termination fee that covers reasonably foreseeable expenses related to the vacancy and reletting of the office space upon early termination of the lease is not a penalty. Such a provision does not reasonably compensate for loss if it provides for payments in excess of actual loss or if it fails to require mitigation of damages.

(4) *Reasonable compensation.* Section 4975(d)(2) and § 54.4975–6(a)(1)(iii) permit a plan to pay a disqualified person reasonable compensation for the provision of office space or services described in section 4975(d)(2). Paragraph (e) of this section contains regulations relating to what constitutes reasonable compensation for the provision of services.

(5) *Transactions with fiduciaries*—(i) *In general.* If the furnishing of office space or a service involves an act described in section 4975(c)(1) (E) or (F) (relating to acts involving conflicts of interest by fiduciaries), such an act constitutes a separate transaction which is not exempt under section 4975(d)(2). The prohibitions of sections 4975(c)(1) (E) and (F) supplement the other prohibitions of section 4975(c)(1) by imposing on disqualified persons who are fiduciaries a duty of undivided loyalty to the plans for which they act. These prohibitions are imposed upon fiduciaries to deter them from exercising the authority, control, or responsibility which makes such persons fiduciaries when they have interests which may conflict with the interests of the plans for which they act. In such cases, the fiduciaries have interests in the transactions which may affect the exercise of their best judgment as fiduciaries. Thus, a fiduciary may not use the authority, control, or responsibility which makes such person a fiduciary to cause a plan to pay an additional fee to such fiduciary (or to a person in which such fiduciary has an interest which may affect the exercise of such fiduciary's best judgment as a fiduciary) to provide a service. Nor may a fiduciary use such authority, control, or responsibility to cause a plan to enter into a transaction involving plan assets whereby such fiduciary (or a person in which such fiduciary has an interest which may affect the exercise of such fiduciary's best judgment as a fiduciary) will receive consideration from a third party in connection with such transaction.

A person in which a fiduciary has an interest which may affect the exercise of such fiduciary's best judgment as a fiduciary includes, for example, a person who is a disqualified person by reason of a relationship to such fiduciary described in section 4975(e)(2) (E), (F), (G), (H), or (I).

(ii) *Transactions not described in section 4975(c)(1)(E).* A fiduciary does not engage in an act described in section 4975(c)(1)(E) if the fiduciary does not use any of the authority, control or responsibility which makes such person a fiduciary to cause a plan to pay additional fees for a service furnished by such fiduciary or to pay a fee for a service furnished by a person in which such fiduciary has an interest which may affect the exercise of such fiduciary's best judgment as a fiduciary. This may occur, for example, when one fiduciary is retained on behalf of a plan by a second fiduciary to provide a service for an additional fee. However, because the authority, control or responsibility which makes a person a fiduciary may be exercised ''in effect'' as well as in form, mere approval of the transaction by a second fiduciary does not mean that the first fiduciary has not used any of the authority, control or responsibility which makes such person a fiduciary to cause the plan to pay the first fiduciary an additional fee for a service.

(iii) *Services without compensation.* If a fiduciary provides services to a plan without the receipt of compensation or other consideration (other than reimbursement of direct expenses properly

and actually incurred in the performance of such services within the meaning of paragraph (e)(4) of this section), the provision of such services does not, in and of itself, constitute an act described in section 4975(c)(1) (E) or (F). The allowance of a deduction to an employer under section 162 or 212 for the expense incurred in furnishing office space or services to a plan established or maintained by such employer does not constitute compensation or other consideration.

(6) *Examples.* The provisions of § 54.4975–6(a)(5) may be illustrated by the following examples:

Example (1). E, an employer whose employees are covered by plan P, is a fiduciary or P. I is a professional investment adviser in which E has no interest which may affect the exercise of E's best judgment as a fiduciary. E causes P to retain I to provide certain kinds of investment advisory services of a type which causes I to be a fiduciary of P under section 4975(e)(3)(B). Thereafter, I proposes to perform for additional fees portfolio evaluation services in addition to the services currently provided. The provision of such services is arranged by I and approved on behalf of the plan by E. I has not engaged in an act described in section 4975(c)(1)(E), because I did not use any of the authority, control or responsibility which makes I a fiduciary (the provision of investment advisory services) to cause the plan to pay I additional fees for the provision of the portfolio evaluation services. E has not engaged in an act which is described in section 4975(c)(1)(E). E, as the fiduciary who has the responsibility to be prudent in his selection and retention of I and the other investments advisers of the plan, has an interest in the purchase by the plan of portfolio evaluation services. However, such an interest is not an interest which may affect the exercise of E's best judgment as a fiduciary.

Example (2). D, a trustee of plan P with discretion over the management and disposition of plan assets, relies on the advice of C, a consultant to P, as to the investment of plan assets, thereby making C a fiduciary of the plan. On January 1, 1978, C recommends to D that the plan purchase an insurance policy from U, an insurance company which is not a disqualified person with respect to P. C thoroughly explains the reasons for the recommendation and makes a full disclosure concerning the fact that C will receive a commission from U upon the purchase of the policy by P. D considers the recommendation and approves the purchase of the policy by P. C receives a commission. Under such circumstances, C has engaged in an act described in section 4975(c)(1)(E) (as well as section 4975(c)(1)(F), because C is in fact exercising the authority, control or responsibility which makes C a fiduciary to cause the plan to purchase the policy. However, the transaction is exempt from the prohibited transaction provisions of section 4975(c)(1) if the requirements of Prohibited Transaction Exemption 77–9 are met.

Example (3). Assume the same facts as in Example (2) except that the nature of C's relationship with the plan is not such that C is a fiduciary of P. The purchase of the insurance policy does not involve an act described in section 4975(c)(1) (E) or (F), because such sections only apply to acts by fiduciaries.

Example (4). E, an employer whose employees are covered by plan P, is a fiduciary with respect to P. A, who is not a disqualified person with respect to P, persuades E that the plan needs the services of a professional investment adviser and that A should be hired to provide the investment advice. Accordingly, E causes P to hire A to provide investment advice of the type which makes A a fiduciary under § 54.4975–9(c)(1)(ii)(B). Prior to the expiration of A's first contract with P, A persuades E to cause P to renew A's contract with P to provide the same services for additional fees in view of the increased costs in providing such services. During the period of A's second contract, A provides additional investment advice services for which no additional charge is made. Prior to the expiration of A's second contract, A persuades E to cause P to renew his contract for additional fees in view of the additional services A is providing. A has not engaged in an act described in section 4975(c)(1)(E), because A has not used any of the authority, control or responsibility which makes A a fiduciary (the provision of investment advice) to cause the plan to pay additional fees for A's services.

Example (5). F, a trustee of plan P with discretion over the management and disposition of plan assets, retains C to provide administrative services to P of the type which makes C a fiduciary under section 4975(e)(3)(C). Thereafter, C retains F to provide, for additional fees, actuarial and various kinds of administrative services in addition to the services F is currently providing to P. Both F and C have engaged in an act described in section 4975(c)(1)(E). F, regardless of any intent which he may have had at the time he retained C, has engaged in such an act because F has, in effect, exercised the authority, control or responsibility which makes F a fiduciary to cause the plan to pay F additional fees for the services. C, whose continued employment by P depends on F, has also engaged in such an act, because C has an interest in the transaction which might affect the exercise of C's best judgment as a fiduciary. As a result, C has dealt with plan assets in his own interest under section 4975(c)(1)(E).

Example (6). F, a fiduciary of plan P with discretionary authority respecting the management of P, retains S, the son of F, to provide for a fee various kinds of administrative services necessary for the operation of the plan. F has engaged in an act described in section 4975(c)(1)(E), because S is a person in whom F has an interest which may affect the exercise of F's best judgment as a fiduciary. Such act is not exempt under section 4975(d)(2) irrespective of whether the provision of the services by S is exempt.

Example (7). T, one of the trustees of plan P, is president of bank B. The bank proposes to provide administrative services to P for a fee. T physically absents himself from all consideration of B's proposal and does not otherwise exercise any of the authority, control or responsibility which makes T a fiduciary to cause the plan to retain B. The other trustees decide to retain B. T has not engaged in an act described in section 4975(c)(1)(E). Further, the other trustees have not engaged in an act described in section 4975(c)(1)(E) merely because T is on the board of trustees of P. This fact alone would not make them have an interest in the transaction which might affect the exercise of their best judgment as fiduciaries.

(b) *Exemption for bank deposits*—(1) *In general.* Section 4975(d)(4) exempts from the excise taxes imposed by section 4975 investment of all or a part of a plan's assets in deposits bearing a reasonable rate of interest in a bank or similar financial institution supervised by the United States or a State, even though such bank or similar financial institution is a fiduciary or other disqualified person with respect to the plan, if the conditions of either § 54.4975–6(b)(2) or § 54.4975–6(b)(3) are met. Section 4975(d)(4) provides an exemption from section 4975(c)(1)(E) relating to fiduciaries dealing with the income or assets of plans in their own interest or for their own account), as well as sections 4975(c)(1) (A) through (D), because section 4975(d)(4) contemplates a bank or similar financial institution causing a plan for which it acts as a fiduciary to invest plan assets in its own deposits if the requirements of section 4975(d)(4) are met. However, it does not provide an exemption from section 4975(c)(1)(F) (relating to fidiciaries receiving consideration for their own personal account from any party dealing with a plan in connection with a transaction involving the income or assets of the plan). The receipt of such consideration is a separate transaction not described in the exemption. Section 4975(d)(4) does not contain an exemption from other provisions of the Code, such as section 401, or other provisions of law which may impose requirements or restrictions relating to the transactions which are exempt under section 4975(d)(4). See, for example, the general fiduciary responsibility provisions of section 404 of the Act. The provisions of section 4975(d)(4) are further limited by the flush language at the end of section 4975(d) (relating to transactions with owner-employees and related persons).

(2) *Plan covering own employees.* Such investment may be made if the plan is one which covers only the employees of the bank or similar financial institution, the employees of any of its affiliates, or the employees of both.

(3) *Other plans*—(i) *General rule.* Such investment may be made if the investment is expressly authorized by a provision of the plan or trust instrument or if the investment is expressly authorized (or made) by a fiduciary of the plan (other than the bank or similar financial institution or any of its affiliates) who has authority to make such investments, or to instruct the trustee or other fiduciary with respect to investments, and who has no interest in the transaction which may affect the exercise of such authorizing fiduciary's best judgment as a fiduciary so as to cause such authorization to constitute an act described in section 4975(c)(1) (E) or (F). Any authorization to make investments contained in a plan or trust instrument will satisfy the requirement of express authorization for investments made prior to November 1, 1977.

Effective November 1, 1977, in the case of a bank or similar financial institution that invests plan assets in deposits in itself or its affiliates under an authorization contained in a plan or trust instrument, such authorization must name such bank or similar financial institution and must state that such bank or similar financial institution may make investments in deposits which bear a reasonable rate of interest in itself (or in an affiliate.)

(ii) *Example.* B, a bank, is the trustee of plan P's assets. The trust instruments give the trustee the right to invest plan assets in its discretion. B invests in the certificates of deposit of bank C, which is a fiduciary of the plan by virtue of performing certain custodial and administrative services. The authorization is sufficient for the plan to make such investment under section 4975(d)(4). Further, such authorization would suffice to allow B to make investments in deposits in itself prior to November 1, 1977. However, subsequent to October 31, 1977, B may not invest in deposits in itself, unless the plan or trust instrument specifically authorizes it to invest in deposits of B.

(4) *Definitions.* (i) The term ''bank or similar financial institution'' includes a bank (as defined in section 581), a domestic building and loan association (as defined in section 7701(a)(19)), and a credit union (as defined in section 101 (6) of the Federal Credit Union Act).

(ii) A person is an affiliate of a bank or similar financial institution if such person and such bank or similar financial institution would be treated as members of the same controlled group of corporations or as members of two or more trades or businesses under common control within the meaning of section 414 (b) or (c) and the regulations thereunder.

(iii) The term ''deposits'' includes any account, temporary or otherwise, upon which a reasonable rate of interest is paid, including a certificate of deposit issued by a bank or similar financial institution.

(c) *Exemption for ancillary bank services*—(1) *In general.* Section 4975(d)(6) exempts from the excise taxes imposed by section 4975 the provision of certain ancillary services by a bank or similar financial institution (as defined in §54.4975–6(b)(4)(i)) supervised by the United States or a State to a plan for which it acts as a fiduciary if the conditions in §54.4975–6(c)(2) are met. Such ancillary services include services which do not meet the requirements of section 4975(d)(2), because the provision of such services involves an act described in section 4975(c)(1)(E) (relating to fiduciaries dealing with the income or assets of plans in their own interest or for their own account) by the fiduciary bank or similar financial institution. Section 4975(d)(6) provides an exemption from section 4975(c)(1)(E), because section 4975 (d)(6) contemplates the provision of such ancillary services without the approval of a second fiduciary (as described in §54.4975–6(a)(5)(ii)) if the conditions of §54.4975–6(c)(2) are met. Thus, for example, plan assets held by a fiduciary bank which are reasonably expected to be needed to satisfy current plan expenses may be placed by the bank in a non-interest-bearing checking account in the bank if the conditions of §54.4975–6(c)(2) are met, notwithstanding the provisions of section 4975(d)(4) (relating to investments in bank deposits). However, section 4975(d)(6) does not provide an exemption for an act described in section 4975(c)(1)(F) (relating to fiduciaries receiving consideration for their own personal account from any party dealing with a plan in connection with a transaction involving the income or assets of the plan). The receipt of such consideration is a separate transaction not described in section 4975(d)(6).

Section 4975(d)(6) does not contain an exemption from other provisions of the Code, such as section 401, or other provisions of law which may impose requirements or restrictions relating to the transactions which are exempt under section 4975(d)(6). See, for example, the general fiduciary responsibility provisions of section 404 of the Act. The provisions of section 4975(d)(6) are further limited by the flush language at the end of section 4975(d) (relating to transactions with owner-employees and related persons).

(2) *Conditions.* Such service must be provided:

(i) At not more than reasonable compensation;

(ii) Under adequate internal safeguards which assure that the provision of such service is consistent with sound banking and financial practice, as determined by Federal or State supervisory authority; and

(iii) Only to the extent that such service is subject to specific guidelines issued by the bank or similar financial institution which meet the requirements of §54.4975–6(c)(3).

(3) *Specific guidelines.* [Reserved]

(d) *Exemption for services as a fiduciary.* [Reserved]

(e) *Compensation for services*—(1) *In general.* Section 4975(d)(2) refers to the payment of reasonable compensation by a plan to a disqualified person for services rendered to the plan. Section 4975(d)(10) and §§ 54.4975–6(e)(2) through 54.4975–6(e)(5) clarify what constitutes reasonable compensation for such services.

(2) *General rule.* Generally, whether compensation is ''reasonable'' under sections 4975(d) (2) and (10) depends on the particular facts and circumstances of each case.

(3) *Payments to certain fiduciaries.* Under sections 4975(d) (2) and (10), the term ''reasonable compensation'' does not include any compensation to a fiduciary who is already receiving full-time pay from an employer or association of employers (any of whose employees are participants in the plan) or from an employee organization (any of whose members are participants in the plan), except for the reimbursement of direct expenses properly and actually incurred and not otherwise reimbursed. The restrictions of this paragraph (e)(3) do not apply to a disqualified person who is not a fiduciary.

(4) *Certain expenses not direct expenses.* An expense is not a direct expense to the extent it would have been sustained had the service not been provided or if it represents an allocable portion of overhead costs.

(5) *Expense advances.* Under sections 4975(d) (2) and (10), the term ''reasonable compensation'', as applied to a fiduciary or an employee of a plan, includes an advance to such a fiduciary or employee by the plan to cover direct expenses to be properly and actually incurred by such person in the performance of such person's duties with the plan if:

(i) The amount of such advance is reasonable with respect to the amount of the direct expense which is likely to be properly and actually incurred in the immediate future (such as during the next month); and

(ii) The fiduciary or employee accounts to the plan at the end of the period covered by the advance for the expenses properly and actually incurred.

(6) *Excessive compensation.* Under sections 4975(d) (2) and (10), any compensation which would be considered excessive under § 1.162–7 (relating to compensation for personal services which constitutes an ordinary and necessary trade or business expense) will not be ''reasonable compensation''. Depending upon the facts and circumstances of the particular situation, compensation which is not excessive under § 1.162–7 may, nevertheless, not be ''reasonable compensation'' within the meaning of sections 4975(d) (2) and (10).

[T.D. 7491, 42 FR 32385, June 24, 1977; 42 FR 37810, July 25, 1977; 43 FR 4604, Feb. 3, 1978]

§ 54.4975–7 Other statutory exemptions.

(a) [Reserved]

(b) *Loans to employee stock ownership plans*—(1) *Definitions.* When used in this paragraph (b) and § 54.4975–11, the terms listed below have the following meanings:

(i) *ESOP.* The term ''ESOP'' refers to an employee stock ownership plan that meets the requirements of section 4975(e)(7) and § 54.4975–11. It is not synonymous with ''stock bonus plan.'' A stock bonus plan must, however, be an ESOP to engage in an exempt loan. The qualification of an ESOP under section 401(a) and § 54.4975–11 will not be adversely affected merely because it engages in a non-exempt loan.

(ii) *Loan.* The term ''loan'' refers to a loan made to an ESOP by a disqualified person or a loan to an ESOP which is guaranteed by a disqualified person. It includes a direct loan of cash, a purchase-money transaction, and an assumption of the obligation of an ESOP, ''Guarantee'' includes an unsecured guarantee and the use of assets of a disqualified person as collateral for a loan, even though the use of assets may not be a guarantee under applicable state law. An amendment of a loan in order to qualify as an exempt loan is not a refinancing of the loan or the making of another loan.

(iii) *Exempt loan.* The term ''exempt loan'' refers to a loan that satisfies the provisions of this paragraph (b). A ''nonexempt loan'' is one that fails to satisfy such provisions.

(iv) *Publicly traded.* The term ''publicly traded'' refers to a security that

is listed on a national securities exchange registered under section 6 of the Securities Exchange Act of 1934 (15 U.S.C. 78f) or that is quoted on a system sponsored by a national securities association registered under section 15A(b) of the Securities Exchange Act (15 U.S.C. 78o).

(v) *Qualifying employer security*. The term ''qualifying employer security'' refers to a security described in § 54.4975–12.

(2) *Statutory exemption*—(i) *Scope*. Section 4975(d)(3) provides an exemption from the excise tax imposed under section 4975 (a) and (b) by reason of section 4975(c)(1) (A) through (E). Section 4975(d)(3) does not provide an exemption from the imposition of such tax by reason of section 4975(c)(1)(F), relating to fiduciaries receiving consideration for their own personal account from any party dealing with a plan in connection with a transaction involving the income or assets of the plan.

(ii) *Special scrutiny of transaction*. The exemption under section 4975(d)(3) includes within its scope certain transaction in which the potential for self-dealing by fiduciaries exists and in which the interests of fiduciaries may conflict with the interests of participants. To guard against those potential abuses, the Internal Revenue Service will subject these transactions to special scrutiny to ensure that they are primarily for the benefit of participants and their beneficiaries. Although the transactions need not be arranged and approved by an independent fiduciary, fiduciaries are cautioned to exercise scrupulously their discretion in approving them. For example, fiduciaries should be prepared to demonstrate compliance with the net effect test and the arm's-length standard under paragraph (b)(3)(ii) and (iii) of this section. Also, fiduciaries should determine that the transaction is truly arranged primarily in the interest of participants and their beneficiaries rather than, for example, in the interest of certain selling shareholders.

(3) *Primary benefit requirement*—(i) *In general*. An exempt loan must be primarily for the benefit of the ESOP participants and their beneficiaries. All the surrounding facts and circumstances, including those described in paragraph (b) (3) (ii) and (iii) of this section, will be considered in determining whether the loan satisfies this requirement. However, no loan will satisfy the requirement unless it satisfies the requirements of paragraph (b) (4), (5), and (6) of this section.

(ii) *Net effect on plan assets*. At the time that a loan is made, the interest rate for the loan and the price of securities to be acquired with the loan proceeds should not be such that plan assets might be drained off.

(iii) *Arm's-length standard*. The terms of a loan, whether or not between independent parties, must, at the same time the loan is made, be at least as favorable to the ESOP as the terms of a comparable loan resulting from arm's-length negotiations between independent parties.

(4) *Use of loan proceeds*. The proceeds of an exempt loan must be used within a reasonable time after their receipt by the borrowing ESOP only for any or all of the following purposes:

(i) To acquire qualifying employer securities.

(ii) To repay such loan.

(iii) To repay a prior exempt loan. A new loan, the proceeds of which are so used, must satisfy the provisions of this paragraph (b).

Except as provided in paragraph (b) (9) and (10) of this section or as otherwise required by applicable law, no security acquired with the proceeds of an exempt loan may be subject to a put, call, or other option, or buy-sell or similar arrangement while held by and when distributed from a plan, whether or not the plan is then an ESOP.

(5) *Liability and collateral of ESOP for loan*. An exempt loan must be without recourse against the ESOP. Furthermore, the only assets of the ESOP that may be given as collateral on an exempt loan are qualifying employer securities of two classes: those acquired with the proceeds of the loan and those that were used as collateral on a prior exempt loan repaid with the proceeds of the current exempt loan. No person entitled to payment under the exempt loan shall have any right to assets of the ESOP other than:

(i) Collateral given for the loan,

(ii) Contributions (other than contributions of employers securities) that

are made under an ESOP to meet its obligations under the loan, and

(iii) Earnings attributable to such collateral and the investment of such contributions.

The payments made with respect to an exempt loan by the ESOP during a plan year must not exceed an amount equal to the sum of such contributions and earnings received during or prior to the year less such payments in prior years. Such contributions and earnings must be accounted for separately in the books of account of the ESOP until the loan is repaid.

(6) *Default.* In the event of default upon an exempt loan, the value of plan assets transferred in satisfaction of the loan must not exceed the amount of default. If the lender is a disqualified person, a loan must provide for a transfer of plan assets upon default only upon and to the extent of the failure of the plan to meet the payment schedule of the loan. For purposes of this subparagraph (6), the making of a guarantee does not make a person a lender.

(7) *Reasonable rate of interest.* The interest rate of a loan must not be in excess of a reasonable rate of interest. All relevant factors will be considered in determining a reasonable rate of interest, including the amount and duration of the loan, the security and guarantee (if any) involved, the credit standing of the ESOP and the guarantor (if any), and the interest rate prevailing for comparable loans. When these factors are considered, a variable interest rate may be reasonable.

(8) *Release from encumbrance*—(i) *General rule.* In general, an exempt loan must provide for the release from encumbrance under this subdivision (i) of plan assets used as collateral for the loan. For each plan year during the duration of the loan, the number of securities released must equal the number of encumbered securities held immediately before release for the current plan year multiplied by a fraction. The numerator of the fraction is the amount of principal and interest paid for the year. The denominator of the fraction is the sum of the numerator plus the principal and interest to be paid for all future years. See § 54.4975–7(b) (8) (iv). The number of future years under the loan must be definitely ascertainable and must be determined without taking into account any possible extensions or renewal periods. If the interest rate under the loan is variable, the interest to be paid in future years must be computed by using the interest rate applicable as of the end of the plan year. If collateral includes more than one class of securities, the number of securities of each class to be released for a plan year must be determined by applying the same fraction to each class.

(ii) *Special rule.* A loan will not fail to be exempt merely because the number of securities to be released from encumbrance is determined solely with reference to principal payments. However, if release is determined with reference to principal payments only, the following three additional rules apply. The first rule is that the loan must provide for annual payments of principal and interest at a cumulative rate that is not less rapid at any time than level annual payments of such amounts for 10 years. The second rule is that interest included in any payment is disregarded only to the extent that it would be determined to be interest under standard loan amoritization tables. The third rule is that this subdivision, (ii) is not applicable from the time that, by reason of a renewal, extension, or refinancing, the sum of the expired duration of the exempt loan, the renewal period, the extension period, and the duration of a new exempt loan exceeds 10 years.

(iii) *Caution against plan disqualification.* Under an exempt loan, the number of securities released from encumbrance may vary from year to year. The release of securities depends upon certain employer contributions and earnings under the ESOP. Under § 54.4975–11(d)(2) actual allocations to participants' accounts are based upon assets withdrawn from the suspense account. Nevertheless, for purposes of applying the limitations under section 415 to these allocations, under § 54.4975–11(a)(8)(ii) contributions used by the ESOP to pay the loan are treated as annual additions to participants' accounts. Therefore, particular caution must be exercised to avoid exceeding the maximum annual additions under section 415. At the same time, release

from encumbrance in annual varying numbers may reflect a failure on the part of the employer to make substantial and recurring contributions to the ESOP which will lead to loss of qualification under section 401(a). The Internal Revenue Service will observe closely the operation of ESOP's that release encumbered securities in varying annual amounts, particularly those that provide for the deferral of loan payments or for balloon payments.

(iv) *Illustration.* The general rule under paragraph (b)(8)(i) of this section operates as illustrated in the following example:

Example. Corporation X establishes an ESOP that borrows $750,000 from a bank. X guarantees the loan, which is for 15 years at 5% interest and is payable in level annual amounts of $72,256.72. Total payments on the loan are $1,083,850.80. The ESOP uses the entire loan proceeds to acquire 15,000 shares of X stock which is used as collateral for the loan. The number of securities to be released for the first year is 1,000 shares, i.e., 15,000 shares × $72,256.72/$1,083,850.80 = 15,000 shares × 1/15. The number of securities to be released for the second year is 1,000 shares, i.e., 14,000 shares × $72,256.72/$1,011,594.08 = 14,000 shares × 1/14. If all loan payments are made as originally scheduled, the number of securities released in each succeeding year of the loan will also be 1,000.

(9) *Right of first refusal.* Qualifying employer securities acquired with proceeds of an exempt loan may, but need not, be subject to a right of first refusal. However, any such right must meet the requirements of this subparagraph (9). Securities subject to such right must be stock or an equity security, or a debt security convertible into stock or an equity security. Also, the securities must not be publicly traded at the time the right may be exercised. The right of first refusal must be in favor of the employer, the ESOP, or both in any order of priority. The selling price and other terms under the right must not be less favorable to the seller than the greater of the value of the security determined under § 54.4975–11(d)(5), or the purchase price and other terms offered by a buyer, other than the employer or the ESOP, making a good faith offer to purchase the security. The right of first refusal must lapse no later than 14 days after the security holder gives written notice to the holder of the right that an offer by a third party to purchase the security has been received.

(10) *Put option.* A qualifying employer security acquired with the proceeds of an exempt loan by an ESOP after September 30, 1976, must be subject to a put option if it is not publicly traded when distributed or if it is subject to a trading limitation when distributed. For purposes of subparagraph (10), a ''trading limitation'' on a security is a restriction under any Federal or state securities law, any regulation thereunder, or an agreement, not prohibited by this paragraph (b), affecting the security which would make the security not as freely tradable as one not subject to such restriction. The put option must be exercisable only by a participant, by the participant's donees, or by a person (including an estate or its distributee) to whom the security passes by reason of a participant's death. (Under this subparagraph (10), *participant* means a participant and beneficiaries of the participant under the ESOP.) The put option must permit a participant to put the security to the employer. Under no circumstances may the put option bind the ESOP. However, it may grant the ESOP an option to assume the rights and obligations of the employer at the time that the put option is exercised. If it is known at the time a loan is made that Federal or state law will be violated by the employer's honoring such put option, the put option must permit the security to be put, in a manner consistent with such law, to a third party (e.g., an affiliate of the employer or a shareholder other than the ESOP) that has substantial net worth at the time the loan is made and whose net worth is reasonably expected to remain substantial.

(11) *Duration of put option*—(i) *General rule.* A put option must be exercisable at least during a 15-month period which begins on the date the security subject to the put option is distributed by the ESOP.

(ii) *Special rule.* In the case of a security that is publicly traded without restriction when distributed but ceases to be so traded within 15 months after distribution, the employer must notify each security holder in writing on or before the tenth day after the date the

security ceases to be so traded that for the remainder of the 15-month period the security is subject to a put option. The number of days between such tenth day and the date on which notice is actually given, if later than the tenth day, must be added to the duration of the put option. The notice must inform distributees of the terms of the put options that they are to hold. Such terms must satisfy the requirements of paragraph (b) (10) through (12) of this section.

(12) *Other put option provisions*—(i) *Manner of exercise.* A put option is exercised by the holder notifying the employer in writing that the put option is being exercised.

(ii) *Time excluded from duration of put option.* The period during which a put option is exercisable does not include any time when a distributee is unable to exercise it because the party bound by the put option is prohibited from honoring it by applicable Federal or state law.

(iii) *Price.* The price at which a put option must be exercisable is the value of the security, determined under § 54.4975–11(d)(5).

(iv) *Payment terms.* The provisions for payment under a put option must be reasonable. The deferral of payment is reasonable if adequate security and a reasonable interest rate are provided for any credit extended and if the cumulative payments at any time are no less than the aggregate of reasonable periodic payments as of such time. Periodic payments are reasonable if annual installments, beginning with 30 days after the date the put option is excercised, are substantially equal. Generally, the payment period may not end more than 5 years after the date the put option is exercised. However, it may be extended to a date no later than the earlier of 10 years from the date the put option is exercised or the date the proceeds of the loan used by the ESOP to acquire the security subject to the put option are entirely repaid.

(v) *Payment restrictions.* Payment under a put option may be restricted by the terms of a loan, including one used to acquire a security subject to a put option made before November 1, 1977. Otherwise, payment under a put option must not be restricted by the provisions of a loan or any other arrangement, including the terms of the employer's articles of incorporation, unless so required by applicable state law.

(13) *Other terms of loan.* An exempt loan must be for a specific term. Such loan may not be payable at the demand of any person, except in the case of default.

(14) *Status of plan as ESOP.* To be exempt, a loan must be made to a plan that is an ESOP at the time of such loan. However, a loan to a plan formally designated as an ESOP at the time of the loan that fails to be an ESOP because it does not comply with section 401(a) of the Code or § 54.4975–11 will be exempt as of the time of such loan if the plan is amended retroactively under section 401(b) or § 54.4975–11(a)(4).

(15) *Special rules for certain loans*—(i) *Loans made before January 1, 1976.* A loan made before January 1, 1976, or made afterwards under a binding agreement in effect on January 1, 1976 (or under renewals permitted by the terms of the agreement on that date) is exempt for the entire period of the loan if it otherwise satisfies the provisions of this paragraph (b) for such period, even though it does not satisfy the following provisions of this section: the last sentence of paragraph (b) (4) and all of paragraph (b) (5), (6), (8) (i) and (ii), and (9) through (13), inclusive.

(ii) *Loans made after December 31, 1975, but before November 1, 1977.* A loan made after December 31, 1975, but before November 1, 1977 or made afterwards under a binding agreement in effect on November 1, 1977 (or under renewals permitted by the terms of the agreement on that date) is exempt for the entire period of the loan if it otherwise satisfies the provisions of this paragraph (b) for such period even though it does not satisfy the following provisions of this section: paragraph (b) (6) and (9) and the three additional rules listed in paragraph (b) (8) (ii).

(iii) *Release rule.* Notwithstanding paragraph (b) (15) (i) and (ii) of this section, if the proceeds of a loan are used to acquire securities after November 1, 1977, the loan must comply by such

date with the provisions of paragraph (b) (8) of this section.

(iv) *Default rule.* Notwithstanding paragraph (b) (15) (i) and (ii) of this section, a loan by a disqualified person other than a guarantor must meet the requirements of paragraph (b) (6) of this section. A loan will meet these requirements if it is retroactively amended before November 1, 1977 to meet these requirements.

(v) *Put option rule.* With respect to a security distributed before November 1, 1977, the put option provisions of paragraph (b) (10), (11), and (12) of this section will be deemed satisfied as of the date the security is distributed if by December 31, 1977, the security is subject to a put option satisfying such provisions, the security is subject to a put option satisfying such provisions. For purposes of satisfying such provisions, the security will be deemed distributed on the date the put option is issued. However, the put option provisions need not be satisfied with respect to a security that is not owned on November 1, 1977, by a person in whose hands a put option must be exercisable.

(Sec. 4975 (e) (7), (88 Stat. 976; 26 U.S.C. 4975 (e) (7)))

[T.D. 7506, 42 FR 44391, Sept. 2, 1977]

§ 54.4975–9 Definition of ''fiduciary''.

(a)–(b) [Reserved]

(c) *Investment advice.* (1) A person shall be deemed to be rendering ''investment advice'' to an employee benefit plan, within the meaning of section 4975(e)(3)(B) and this paragraph, only if:

(i) Such person renders advice to the plan as to the value of securities or other property, or makes recommendations as to the advisability of investing in, purchasing, or selling securities or other property; and

(ii) Such person either directly or indirectly (e.g., through or together with any affiliate):

(A) Has discretionary authority or control, whether or not pursuant to agreement, arrangement or understanding, with respect to purchasing or selling securities or other property for the plan; or

(B) Renders any advice described in paragraph (c)(1)(i) of this section on a regular basis to the plan pursuant to a mutual agreement, arrangement or understanding, written or otherwise, between such person and the plan or a fiduciary with respect to the plan, that such services will serve as a primary basis for investment decisions with respect to plan assets, and that such person will render individualized investment advice to the plan based on the particular needs of the plan regarding such matters as, among other things, investment policies or stategy, overall portfolio composition, or diversification of plan investments.

(2) A person who is a fiduciary with respect to a plan by reason of rendering investment advice (as defined in paragraph (c)(1) of this section) for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or having any authority or responsibility to do so, shall not be deemed to be a fiduciary regarding any assets of the plan with respect to which such person does not have any discretionary authority, discretionary control or discretionary responsibility, does not exercise any authority or control, does not render investment advice (as defined in paragraph (c)(1) of this section) for a fee or other compensation, and does not have any authority or responsibility to render such investment advice, provided that nothing in this paragraph shall be deemed to:

(i) Exempt such person from the provisions of section 405(a) of the Employee Retirement Income Security Act of 1974 concerning liability for fiduciary breaches by other fiduciaries with respect to any assets of the plan; or

(ii) Exclude such person from the definition of the term *disqualified person* (as set forth in section 4975(e)(2)) with respect to any assets of the plan.

(d) *Execution of securities transactions.* (1) A person who is a broker or dealer registered under the Securities Exchange Act of 1934, a reporting dealer who makes primary markets in securities of the United States Government or of an agency of the United States Government and reports daily to the Federal Reserve Bank of New York its positions with respect to such securities and borrowings thereon, or a bank supervised by the United States or a

State, shall not be deemed to be a fiduciary, within the meaning of section 4975(e)(3), with respect to an employee benefit plan solely because such person executes transactions for the purchase or sale of securities on behalf of such plan in the ordinary course of its business as a broker, dealer, or bank, pursuant to instructions of a fiduciary with respect to such plan, if:

(i) Neither the fiduciary nor any affiliate of such fiduciary is such broker, dealer, or bank; and

(ii) The instructions specify (A) the security to be purchased or sold, (B) a price range within which such security is to be purchased or sold, or, if such security is issued by an open-end investment company registered under the Investment Company Act of 1940 (15 U.S.C. 80a-1, *et seq.*), a price which is determined in accordance with Rule 22c-1 under the Investment Company Act of 1940 (17 CFR 270.22c-1), (C) a time span during which such security may be purchased or sold (not to exceed five business days), and (D) the minimum or maximum quantity of such security which may be purchased or sold within such price range, or, in the case of security issued by an open-end investment company registered under the Investment Company Act of 1940, the minimum or maximum quantity of such security which may be purchased or sold, or the value of such security in dollar amount which may be purchased or sold, at the price referred to in paragraph (d)(1)(ii)(B) of this section.

(2) A person who is a broker-dealer, reporting dealer, or bank which is a fiduciary with respect to an employee benefit plan solely by reason of the possession or exercise of discretionary authority or discretionary control in the management of the plan or the management or disposition of plan assets in connection with the execution of a transaction or transactions for the purchase or sale of securities on behalf of such plan which fails to comply with the provisions of paragraph (d)(1) of this section, shall not be deemed to be a fiduciary regarding any assets of the plan with respect to which such broker-dealer, reporting dealer or bank does not have any discretionary authority, discretionary control or discretionary responsibility, does not exercise any authority or control, does not render investment advice (as defined in paragraph (c)(1) of this section) for a fee or other compensation, and does not have any authority or responsibility to render such investment advice, provided that nothing in this paragraph shall be deemed to:

(i) Exempt such broker-dealer, reporting dealer, or bank from the provisions of section 405(a) of the Employee Retirement Income Security Act of 1974 concerning liability for fiduciary breaches by other fiduciaries with respect to any assets of the plan; or

(ii) Exclude such broker-dealer, reporting dealer, or bank from the definition of the term *disqualified person* (as set forth in section 4975(e)(2)) with respect to any assets of the plan.

(e) *Affiliate and control.* (1) For purposes of paragraphs (c) and (d) of this section, an ''affiliate'' of a person shall include:

(i) Any person directly or indirectly, through one or more intermediaries, controlling, controlled by, or under common control with such person;

(ii) Any officer, director, partner, employee or relative (as defined in section 4975(e)(6)) of such person; and

(iii) Any corporation or partnership of which such person is an officer, director or partner.

(2) For purposes of this paragraph, the term *control* means the power to exercise a controlling influence over the management or policies of a person other than an individual.

[T.D. 7386, 40 FR 50841, Oct. 31, 1975]

§ 54.4975–11 ''ESOP'' requirements.

(a) *In general*—(1) *Type of plan.* To be an ''ESOP'' (employee stock ownership plan), a plan described in section 4975(e)(7)(A) must meet the requirements of this section. See section 4975(e)(7)(B).

(2) *Designation as ESOP.* To be an ESOP, a plan must be formally designated as such in the plan document.

(3) *Continuing loan provisions under plan*—(i) *Creation of protections and rights.* The terms of an ESOP must formally provide participants with certain protections and rights with respect to plan assets acquired with the proceeds of an exempt loan. These protections and rights are those referred to in the

third sentence of § 54.4975–7(b)(4), relating to put, call, or other options and to buy-sell or similar arrangements, and in § 54.4975–7(b) (10), (11), and (12), relating to put options.

(ii) ''*Nonterminable*'' *protections and rights.* The terms of an ESOP must also formally provide that these protections and rights are nonterminable. Thus, if a plan holds or has distributed securities acquired with the proceeds of an exempt loan and either the loan is repaid or the plan ceases to be an ESOP, these protections and rights must continue to exist under the terms of the plan. However, the protections and rights will not fail to be nonterminable merely because they are not exercisable under § 54.4975–7(b) (11) and (12)(ii). For example, if, after a plan ceases to be an ESOP, securities acquired with the proceeds of an exempt loan cease to be publicly traded, the 15-month period prescribed by § 54.4975–7(b)(11) includes the time when the securities are publicly traded.

(iii) *No incorporation by reference of protections and rights.* The formal requirements of paragraph (a)(3) (i) and (ii) of this section must be set forth in the plan. Mere reference to the third sentence of § 54.4975–7(b)(4) and to the provisions of § 54.4975–7(b) (10), (11), and (12) is not sufficient.

(iv) *Certain remedial amendments.* Notwithstanding the limits under paragraph (a) (4) and (10) of this section on the retroactive effect of plan amendments, a remedial plan amendment adopted before December 31, 1979, to meet the requirements of paragraph (a)(3) (i) and (ii) of this section is retroactively effective as of the later of the date on which the plan was designated as an ESOP or November 1, 1977.

(4) *Retroactive amendment.* A plan meets the requirements of this section as of the date that it is designated as an ESOP if it is amended retroactively to meet, and in fact does meet, such requirements at any of the following times:

(i) 12 months after the date on which the plan is designated as an ESOP;

(ii) 90 days after a determination letter is issued with respect to the qualification of the plan as an ESOP under this section, but only if the determination is requested by the time in paragraph (a)(4)(i) of this section; or

(iii) A later date approved by the district director.

(5) *Addition to other plan.* An ESOP may form a portion of a plan the balance of which includes a qualified pension, profit-sharing, or stock bonus plan which is not an ESOP. A reference to an ESOP includes an ESOP that forms a portion of another plan.

(6) *Conversion of existing plan to an ESOP.* If an existing pension, profit-sharing, or stock bonus plan is converted into an ESOP, the requirements of section 404 of the Employee Retirement Income Security Act of 1974 (ERISA) (88 Stat. 877), relating to fiduciary duties, and section 401(a) of the Code, relating to requirements for plans established for the exclusive benefit of employees, applying to such conversion. A conversion may constitute a termination of an existing plan. For definition of a termination, see the regulations under section 411(d)(3) of the Code and section 4041(f) of ERISA.

(7) *Certain arrangements barred*—(i) *Buy-sell agreements.* An arrangement involving an ESOP that creates a put option must not provide for the issuance of put options other than as provided under § 54.4975–7(b) (10), (11) and (12). Also, an ESOP must not otherwise obligate itself to acquire securities from a particular security holder at an indefinite time determined upon the happening of an event such as the death of the holder.

(ii) *Integrated plans.* A plan designated as an ESOP after November 1, 1977, must not be integrated directly or indirectly with contributions or benefits under title II of the Social Security Act or any other State or Federal law. ESOP's established and integrated before such date may remain integrated. However, such plans must not be amended to increase the integration level or the integration percentage. Such plans may in operation continue to increase the level of integration if under the plan such increase is limited by reference to a criterion existing apart from the plan.

(8) *Effect of certain ESOP provisions on section 401(a) status*—(i) *Exempt loan requirements.* An ESOP will not fail to

meet the requirements of section 401(a)(2) merely because it gives plan assets as collateral for an exempt loan under § 54.4975–7(b)(5) or uses plan assets under § 54.4975–7(b)(6) to repay and exempt loan in the event of default.

(ii) *Individual annual contribution limitation.* An ESOP will not fail to meet the requirements of section 401(a)(16) merely because annual additions under section 415(c) are calculated with respect to employer contributions used to repay an exempt loan rather than with respect to securities allocated to participants.

(iii) *Income pass-through.* An ESOP will not fail to meet the requirements of section 401(a) merely because it provides for the current payment of income under paragraph (f)(3) of this section.

(9) *Transitional rules for ESOP's established before November 1, 1977.* A plan established before November 1, 1977 that otherwise satisfies the provisions of this section constitutes an ESOP if it is amended by December 31, 1977, to comply from November 1, 1977 with this section even though before November 1, 1977 the plan did not satisfy paragraphs (c) and (d) (2), (4), and (5) of this section.

(10) *Additional transitional rules.* Notwithstanding paragraph (a)(9) of this section, a plan established before November 1, 1977, that otherwise satisfies the provisions of this section constitutes an ESOP if by December 31, 1977, it is amended to comply from November 1, 1977, with this section even though before such date the plan did not satisfy the following provisions of this section:

(i) Paragraph (a) (3) and (8) (iii);

(ii) The last sentence of paragraph (d)(3); and

(iii) Paragraph (f)(3).

(b) *Plan designed to invest primarily in qualifying employer securities.* A plan constitutes an ESOP only if the plan specifically states that it is designed to invest primarily in qualifying employer securities. Thus, a stock bonus plan or a money purchase pension plan constituting an ESOP may invest part of its assets in other than qualifying employer securities. Such plan will be treated the same as other stock bonus plans or money purchase pension plans qualified under section 401a with respect to those investments.

(c) *Suspense account.* All assets acquired by an ESOP with the proceeds of an exempt loan under section 4975(d)(3) must be added to and maintained in a suspense account. They are to be withdrawn from the suspense account by applying § 54.4975–7(b) (8) and (15) as if all securities in the suspense account were encumbered. Such assets acquired before November 1, 1977, must be withdrawn by applying § 54.4975–7(b)(8) or the provision of the loan that controls release from encumbrance. Assets in such suspense accounts are assets of the ESOP. Thus, for example, such assets are subject to section 401(a)(2).

(d) *Allocations to accounts of participants*—(1) *In general.* Except as provided in this section, amounts contributed to an ESOP must be allocated as provided under § 1.401–1(b)(ii) and (iii) of this chapter, and securities acquired by an ESOP must be accounted for as provided under § 1.402(a)–1(b)(2)(ii) of this chapter.

(2) *Assets withdrawn from suspense account.* As of the end of each plan year, the ESOP must consistently allocate to the participants' accounts non-monetary units representing participants' interests in assets withdrawn from the suspense account.

(3) *Income.* Income with respect to securities acquired with the proceeds of an exempt loan must be allocated as income of the plan except to the extent that the ESOP provides for the use of income from such securities to repay the loan. Certain income may be distributed currently under paragraph (f)(3) of this section.

(4) *Forfeitures.* If a portion of a participant's account is forfeited, qualifying employer securities allocated under paragraph (d)(2) of this section must be forfeited only after other assets. If interests in more than one class of qualifying employer securities have been allocated to the participant's account, the participant must be treated as forfeiting the same proportion of each such class.

(5) *Valuation.* For purposes of § 54.4975–7(b) (9) and (12) and this section, valuations must be made in good faith and based on all relevant factors for determining the fair market value

of securities. In the case of a transaction between a plan and a disqualified person, value must be determined as of the date of the transaction. For all other purposes under this subparagraph (5), value must be determined as of the most recent valuation date under the plan. An independent appraisal will not in itself be a good faith determination of value in the case of a transaction between a plan and a disqualified person. However, in other cases, a determination of fair market value based on at least an annual appraisal independently arrived at by a person who customarily makes such appraisals and who is independent of any party to a transaction under § 54.4975–7(b) (9) and (12) will be deemed to be a good faith determination of value.

(e) *Multiple plans*—(1) *General rule.* An ESOP may not be considered together with another plan for purposes of applying section 401(a) (4) and (5) or section 410(b) unless:

(i) The ESOP and such other plan exist on November 1, 1977, or

(ii) Paragraph (e)(2) of this section is satisfied.

(2) *Special rule for combined ESOP's.* Two or more ESOP's, one or more of which does not exist on November 1, 1977, may be considered together for purposes of applying section 401(a) (4) and (5) or section 410(b) only if the proportion of qualifying employer securities to total plan assets is substantially the same for each ESOP and:

(i) The qualifying employer securities held by all ESOP's are all of the same class; or

(ii) The ratios of each class held to all such securities held is substantially the same for each plan.

(3) *Amended coverage, contribution, or benefit structure.* For purposes of paragraph (e)(1)(i) of this section, if the coverage, contribution, or benefit structure of a plan that exists on November 1, 1977 is amended after that date, as of the effective date of the amendment, the plan is no longer considered to be a plan that exists on November 1, 1977.

(f) *Distribution*—(1) *In general.* Except as provided in paragraph (f) (2) and (3) of this section, with respect to distributions, a portion of an ESOP consisting of stock bonus plan or a money purchase pension plan is not to be distinguished from other such plans under section 401(a). Thus, for example, benefits distributable from the portion of an ESOP consisting of a stock bonus plan are distributable only in stock of the employer. Also, benefits distributable from the money-purchase portion of the ESOP may be, but are not required to be, distributable in qualifying employer securities.

(2) *Exempt loan proceeds.* If securities acquired with the proceeds of an exempt loan available for distribution consist of more than one class, a distributee must receive substantially the same proportion of each such class. However, as indicated in paragraph (f)(1) of this section, benefits distributable from the portion of an ESOP consisting of a stock bonus plan are distributable only in stock of the employer.

(3) *Income.* Income paid with respect to qualifying employer securities acquired by an ESOP in taxable years beginning after December 31, 1974, may be distributed at any time after receipt by the plan to participants on whose behalf such securities have been allocated. However, under an ESOP that is a stock bonus plan, income held by the plan for a 2-year period or longer must be distributed under the general rules described in paragraph (f)(1) of this section. (See the last sentence of section 803(h), Tax Reform Act of 1976.)

(Sec. 4975(e)(7), (88 Stat. 976; 26 U.S.C. 4975(e)(7)))

[T.D. 7506, 42 FR 44393, Sept. 2, 1977, as amended by T.D. 7571, 44 FR 1978, Jan. 9, 1979]

§ 54.4975–12 Definition of the term ''qualifying employer security''.

(a) *In general.* For purposes of section 4975(e)(8) and this section, the term ''qualifying employer security'' means an employer security which is:

(1) Stock or otherwise an equity security, or

(2) A bond, debenture, note, or certificate or other evidence of indebtedness which is described in paragraphs (1), (2), and (3) of section 503(e).

(b) *Special rule.* In determining whether a bond, debenture, note, or

certificate or other evidence of indebtedness is described in paragraphs (1), (2), and (3) of section 503(e), any organization described in section 401(a) shall be treated as an organization subject to the provisions of section 503.

(Sec. 4975(e)(7) (88 Stat. 976; 26 U.S.C. 4975(e)(7)))

[T.D. 7506, 42 FR 44394, Sept. 2, 1977]

§ 54.4975–14 Election to pay an excise tax for certain pre-1975 prohibited transactions.

(a) *In general.* Section 2003(c)(1)(B) of the Employee Retirement Income Security Act of 1974 (88 Stat. 978) provides an election to pay an excise tax by certain persons involved prior to 1975 in prohibited transactions within the meaning of section 503 (b) or (g).

(b) *Effect of election.* If a valid election is made under this section with respect to a particular transaction, any loss of exemption under section 501(a) because of a prohibited transaction within the meaning of section 503 (b) or (g) shall not apply. Instead, the person who made the election referred to in this section shall be subject to the taxes which would have been imposed by section 4975 (a) or (b) as though section 4975 had imposed a tax in respect of the transaction. (However, section 4975(f)(1), relating to joint and several liability, shall not apply to any person who has not made an election under this section, and interest for late payment of tax shall not begin to accrue until after the date of the election.) Such an election is irrevocable. However, the making of the election does not affect the application of section 6501 for purposes of assessment and collection of tax and section 6511 for purposes of filing a claim for credit or refund with respect to taxpayers and to taxable years of taxpayers whose tax liability is or may be affected by reason of the nonapplication of a denial of exempt status.

(c) *Method of election.* A person shall make the election referred to in this section by filing the form issued for such purpose by the Internal Revenue Service, including therein the information required by such form and the instructions issued with respect thereto, and by paying the tax which the taxpayer indicates is due at the time the return is filed. To be valid the election must be made prior to the later of December 6, 1976, or 120 days after the date of notification referred to in §1.503(a)–1(b) of this chapter (Income Tax Regulations), relating to loss of exemption for certain prohibited transactions. If there has been no notification of loss of exemption, the election may be made at any time. However, these limitations do not preclude an agreement between the disqualified person and the district director to extend the time within which the election is permitted.

(d) *Computation of section 4975 excise tax.* To the extent applicable, and solely for purposes associated with the payment of a section 4975 excise tax under the election referred to in this section, §53.4941(e)–1 of this chapter (Foundation Excise Tax Regulations) is controlling.

(Sec. 2003(c)(1)(B) of the Employee Retirement Income Security Act of 1974 (88 Stat. 978))

[T.D. 7489, 42 FR 27882, June 1, 1977]

§ 54.4975–15 Other transitional rules.

(a)–(c) [Reserved]

(d) *Provision of certain services until June 30, 1977*—(1) *In general.* Section 2003(c)(2)(D) of the Employee Retirement Income Security Act of 1974 (the Act) (88 Stat. 979) provides that section 4975 shall not apply to the provision of services before June 30, 1977, between a plan and a disqualified person if the three requirements contained in section 2003(c)(2)(D) of the Act are met. The first requirement is that such services must be provided either (in) under a binding contract in effect on July 1, 1974 (or pursuant to a renewal or modification of such contract); or (ii) by a disqualified person who ordinarily and customarily furnished such services on June 30, 1974. The second requirement is that the services be provided on terms that remain at least as favorable to the plan as an arm's-length transaction with an unrelated party would be.

For this purpose, such services are provided on terms that remain at least as favorable to the plan as an arms-length transaction with an unrelated party would be if, at the time of execution

(or renewal) of such binding contract, the contract (or renewal) is on terms at least as favorable to the plan as an arm's-length transaction with an unrelated party would be. However, if in a normal commercial setting an unrelated party in the position of the plan could be expected to insist upon a renegotiation or termination of a binding contract, the plan must so act. Thus, for example, if a disqualified person provides services to a plan on a month-to-month basis, and a party in the position of the plan could be expected to renegotiate the price paid under such contract because of a decline in the fair market value of such services, the plan must so act in order to avoid participation in a prohibited transaction. The third requirement is that the provision of services must not be, or have been, at the time of such provision a prohibited transaction within the meaning of section 503(b) or the corresponding provisions of prior law. If these three requirements are met, section 4975 will apply neither to services provided before June 30, 1977 (both to customers to whom such services were being provided on June 30, 1974, and to new customers) nor to the receipt of compensation therefor. Thus, if these three requirements are met, section 4975 will not apply until June 30, 1977, to the provision of services to a plan by a disqualified person (including a fiduciary) even if such services could not be furnished pursuant to the exemption provisions of sections 4975(d)(2) or (6) and §54.4975–6. For example, if the three requirements of section 2003(c)(2)(D) of the Act are met, a person serving as fiduciary to a plan who already receives full-time pay from an employer or an association of employers, whose employees are participants in such plan, or from an employee organization whose members are participants in such plan, may continue to receive reasonable compensation from the plan for services rendered to the plan before June 30, 1977. Similarly, until June 30, 1977, a plan consultant who may be a fiduciary because of the nature of the consultative and administrative services being provided may, if these three requirements are met, continue to cause the sale of insurance to the plan and continue to receive commissions for such sales from the insurance company writing the policy. Further, if the three requirements of section 2003 (c)(2)(D) of the Act are met, a securities broker dealer who renders investment advice to a plan for a fee, thereby becoming a fiduciary may furnish other services to the plan, such as brokerage services, and receives compensation therefor. Also, if a registered representative of such a broker-dealer were a fiduciary, the registered representative may receive compensation, including commissions, for brokerage services performed before June 30, 1977.

(2) *Persons deemed to be June 30, 1974, service providers.* A disqualified person with respect to a plan which did not, on June 30, 1974, ordinarily and customarily furnish a particular service, will nevertheless be considered to have ordinarily and customarily furnished such service on June 30, 1974, for purposes of this section and section 2003(c)(2)(D) of the Act, if either of the following conditions are met:

(i) At least 50 percent of the outstanding beneficial interests of such disqualified person are owned directly or through one or more intermediaries by the same person or persons who owned, directly or through one or more intermediaries, at least 50 percent of the outstanding beneficial interests of a person who ordinarily and customarily furnished such service on June 30, 1974; or

(ii) Control, or the power to exercise a controlling influence over the management and policies of such disqualified person is possessed, directly or through one or more intermediaries, by the same person or persons who possessed directly or through one or more intermediaries control, or the power to exercise a controlling influence over the management and policies of a person who ordinarily and customarily furnished such service on June 30, 1974. For purposes of this paragraph (d)(2) a person shall be deemed to be an ''intermediary'' of another person if at least 50 percent of the outstanding beneficial interests of such person are owned by such other person, directly or indirectly, or if such other person controls or has the power to exercise a controlling influence over the management and policies of such person.

(3) *Examples.* The principals of § 54.4975–15(d)(2) may be illustrated by the following examples.

Example (1). A owns 50 percent of the outstanding beneficial interests of ABC Partnership which ordinarily and customarily furnished certain services on June 30, 1974. On July 2, 1974, ABC Partnership was incorporated into ABC Corporation with one class of stock outstanding. A owns 50 percent of the shares of such stock. ABC Corporation furnishes the same services that were furnished by ABC Partnership on June 30, 1974. ABC Corporation will be deemed to have ordinarily and customarily furnished such services on June 30, 1974, for purposes of section 2003(c)(2)(D) of the Act.

Example (2). A and B together own 100 percent of the beneficial interests of AB Partnership, which ordinarily and customarily furnished certain services on June 30, 1974. On September 1, 1974, AB Partnership was incorporated into AB Corporation with one class of stock outstanding. A and B each own 20 percent of such outstanding class of stock and together have control over the management and policies of AB Corporation. AB Corporation furnishes the same services that were furnished by AB Partnership on June 30, 1974. AB Corporation will be deemed to have ordinarily and customarily furnished such services on June 30, 1974, for purposes of section 2003(c)(2)(D) of the Act.

Example (3). On June 30, 1974, M Corporation was ordinarily and customarily furnishing certain services. On that date, X, Y and Z together owned 50 percent of all classes of the outstanding shares of M Corporation. On January 28, 1975, all of the shareholders of M Corporation exchanged their shares in M Corporation for shares of a new N Corporation. As a result of that exchange, X, Y and Z together own 50 percent of the common stock of N Corporation, the only class of N Corporation stock outstanding after the exchange. N Corporation furnishes the services formerly furnished by M Corporation. N Corporation will be deemed to have ordinarily and customarily furnished such services on June 30, 1974, for purposes of section 2003(c)(2)(D) of the Act.

Example (4). I Corporation ordinarily and customarily furnished certain services on June 30, 1974. On November 3, 1975, I Corporation organizes a wholly owned subsidiary, S Corporation, which furnishes the same services ordinarily and customarily furnished by I Corporation on June 30, 1974. S Corporation will be deemed to have ordinarily and customarily furnished such services on June 30, 1974, for purposes of section 2003(c)(2)(D) of the Act.

Example (5). X Corporation, wholly-owned and controlled by A, ordinarily and customarily furnished certain services on June 30, 1974. Y Corporation did not perform such services on that date. On January 2, 1976, X Corporation is merged into Y Corporation and although A received less than 50 percent of the total outstanding shares of Y Corporation, after such merger A has control over the management and policies of Y Corporation. Y Corporation furnishes the same services that were formerly furnished by X Corporation. Y Corporation will be deemed to have ordinarily and customarily furnished such services on June 30, 1974, for purposes of section 2003(c)(2)(D) of the Act.

[T.D. 7491, 42 FR 32388, June 24, 1977]

§ 54.4976–1T Questions and answers relating to taxes with respect to welfare benefit funds (temporary).

Q–1: What does section 4976 provide?

A–1: Section 4976 imposes a tax on employers who provide disqualified benefits through a welfare benefit fund. The tax imposed is equal to 100 percent of the disqualified benefit.

Q–2: What constitutes a disqualified benefit?

A–2: A disqualified benefit is (a) any post-retirement medical or life insurance benefit provided with respect to a key employee (as defined in section 419A(d)(3)) through a welfare benefit fund if a separate account is required to be established for such employee under section 419A(d) and the cost for such coverage is not charged against or paid from such separate account; (b) any post-retirement medical or life insurance benefit provided through a welfare benefit fund with respect to an individual in whose favor discrimination is prohibited unless the plan of which the fund is a part meets the requirements of section 505(b) with respect to that benefit; and (c) any portion of the fund which reverts to the benefit of the employer. A post-retirement medical or life insurance benefit provided with respect to a key employee will not constitute a disqualified benefit even though such benefit is not provided through a separate account if the cost of such benefit is paid by the employer in the taxable year in which the benefit is provided and there is not (and there is not required to be) a separate account with an outstanding credit balance maintained for the key employee.

Q–3: What is the effective date of section 4976?

A–3: (a) Generally, section 4976 applies to disqualified benefits provided

by a welfare benefit fund after December 31, 1985. However, a disqualified benefit, as defined in section 4976(b)(1) or (2), is not subject to section 4976(a) if it is provided from ''existing reserves for post-retirement medical or life insurance benefits'' that are within the transition rule set forth in section 512(a)(3)(E)(iii) and Q&A–4 of §1.512(a)–5T (or would be if such transition rule applied to such welfare benefit fund). For example, if a welfare benefit fund in existence on July 18, 1984, provides an individual in whose favor discrimination is prohibited with a post-retirement life insurance benefit after December 31, 1985, that does not meet the requirements of section 505(b) and if the welfare benefit fund received no contributions after July 18, 1984, then the disqualified benefit provided by the fund is not subject to section 4976(a)

(b) A welfare benefit fund will be able to avoid the application of section 4976(b)(1) and (2) if the employer withdraws from such fund, before April 7, 1986, any amounts that are not attributable to ''existing reserves for post-retirement medical or life insurance benefits'' because they were neither actually set aside nor treated as actually set aside under Q&A–4 of §1.512(a)–5T, on July 18, 1984. The employer making such a withdrawal must include the amount in income for the first taxable year ending after July 18, 1984, or, to the extent that the withdrawn amount is attributable to the following taxable year, for such following taxable year. Such a withdrawal will not be treated as an impermissible distribution or reversion under section 501(c)(9), and will not be treated as a disqualified benefit under section 4976(b)(3). Of course, to the extent that the welfare benefit fund contains amounts that are attributable to ''existing reserves'' but are not within the transition rule set forth in Q&A–4 of §1.512(a)–5T (as applied to welfare benefit funds), for example, because such amounts exceed the amounts that could have been accumulated under the principles set forth in Revenue Rulings 69–382, 1969–2 C.B. 28; 69–478, 1969–2 C.B. 29; and 73–599, 1973–2 C.B. 40, the fund will not be able to avoid the application of section 4976(b)(1) and (2) under this paragraph.

(c) In the case of a plan which is maintained pursuant to one or more collective bargaining agreements (1) between employee representatives and one or more employers and (2) which are in effect on July 1, 1985 (or ratified on or before that date), the provision does not apply to disqualified benefits provided in years beginning before the termination of the last of the collective bargaining agreements pursuant to which the plan is maintained (determined without regard to any extension of the contract agreed to after July 1, 1985). For purposes of the preceding sentence, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added under section 511 of the Tax Reform Act 1984 (i.e., requirements under sections 419, 419A, 512(a)(3)(E), and 4976) shall not be treated as a termination of such collective bargaining agreement.

[T.D. 8073, 51 FR 4336, Feb. 4, 1986]

§54.4977–1T Questions and answers relating to the election concerning lines of business in existence on January 1, 1984 (temporary).

The following questions and answers relate to the election by employers under section 4977 of the Internal Revenue Code of 1954, as added by section 531(e)(1) of the Tax Reform Act of 1984 (98 Stat. 886), to treat all employees of any line of business in existence on January 1, 1984, as employees of one of those lines of business for purposes of section 132(a) (1) and (2):

Q–1: What does section 4977 provide with respect to the exclusion from gross income of certain fringe benefits?

A–1: In general, section 4977 provides an elective grandfather rule that allows an employer under certain circumstances to treat employees of all lines of business which were in existence on January 1, 1984, as employees of one of those lines of business for purposes of section 132(a) (1) and (2), but not for purposes of section 132(g)(2).

Q–2: Under what circumstances does the elective grandfather rule of section 4977 apply?

A–2: If:

(a) An election under section 4977 is in effect with respect to an employer for any calendar year, and

(b) On and after January 1, 1984, at least 85 percent of the employees of the employer in all of its lines of business which existed on January 1, 1984, were entitled to employee discounts or services provided by the employer in one line of business,

then all employees of any line of business of the employer which was in existence on January 1, 1984, are treated, for purposes of section 132(a) (1) and (2) (but not for purposes of section 132(g)(2)) as employees of the one line of business referred to in (b) of this Q/A–2.

Q–3: How does an employer make the election provided for in section 4977?

A–3: An employer must file a statement with the director of the service center with which the employer's tax returns are filed. The statement must indicate that the employer is electing to apply the provisions of section 4977 to one or more of the employer's lines of business and must contain the following information:

(a) The employer's name, address, and taxpayer identification number;

(b) A description of all of the employer's lines of business in existence on January 1, 1984; and

(c) For each lines of business which is to have as an employee for purposes of section 132(a) (1) and (2) an individual but for the election under section 4977 would not be treated as an employee for purposes of section 132(a) (1) and (2):

(1) A description of the no-additional-cost service or qualified employee discount (including, with respect to discounts, the percentage discount) to be offered to employees pursuant to section 4977 in such line of business, and

(2) With respect to employees in all of the employer's lines of business in existence on January 1, 1984, the number of such employees and the number entitled to the described fringe benefit. Such numbers may be determined as of a date which does not precede the date the election is filed by more than 30 days.

Q–4: In order to make a timely section 4977 election, when must an employer file the election statement?

A–4: Except as otherwise provided in the second sentence of this answer, the employer must file the election statement before the end of the calendar year preceding the year for which the election is to apply. For calendar year 1985, however, the employer has until March 31, 1985, to file the election statement. However, the Commissioner may, in his discretion, extend the March 31, 1985 deadline to a later date.

Q–5: Does section 4977 apply to all calendar years following the calendar year in which the election is made?

A–5: Yes, unless the employer revokes the election.

Q–6: When is a revocation effective?

A–6: A revocation is effective with respect to the calendar year following the calendar year in which it is filed.

Q–7: If an employer does not make a timely section 4977 election with respect to 1985, will the employer be entitled to make an election with respect to any subsequent year?

A–7: No.

Q–8: If an employer revokes a section 4977 election, is the employer entitled to elect the application of section 4977 for subsequent years?

A–8: No.

[T.D. 8004, 50 FR 758, Jan. 7, 1985]

§ 54.4978–1T Questions and answers relating to the tax on certain dispositions by employee stock ownership plans and certain cooperatives (temporary).

Q–1: What does section 4978 provide?

A–1: Section 4978 imposes a tax (as determined under section 4978(b) and Q&A–2 of this section) on the amount realized on the disposition of any qualified securities, if:

(a) An employee stock ownership plan or eligible worker-owned cooperative acquires any qualified securities in a sale to which section 1042 applies;

(b) Such plan or cooperative disposes of any qualified securities during the 3-year period after the date on which any qualified securities were acquired in the sale to which section 1042 applies; and

(c) Either (1) the percentage of the total outstanding shares of the class of employer securities of which the disposed qualified securities are a part held by such plan or cooperative after

such disposition is less than the percentage of the total outstanding shares of such class of employer securities held immediately after the sale to which section 1042 applies, or (2) the value of the employer securities held by such plan or cooperative immediately after such disposition is less than 30 percent of the total value of all employer securities outstanding at that time. For purposes of this section, the following terms have the same meanings given to such terms by the identified provisions: ''employee stock ownership plan'' (section 4975(e)(7)); ''qualified securities'' (section 1042(b)(1)); ''eligible worker-owned cooperative'' (section 1042(b)(2)); ''employer securities'' (section 409(l)). For purposes of determining what constitutes a disposition to which section 4978 applies, see Q&A–3 of this section.

Q–2: What is the amount of tax imposed under section 4978?

A–2: Section 4978 imposes a tax of 10 percent of the amount realized on the disposition of qualified securities. The amount realized that is subject to tax under section 4978 shall not exceed that portion of the amount realized that is allocable to qualified securities acquired within the 3-year period prior to the date of disposition and to which section 1042 applied (''restricted qualified securities''). In determining the amount realized (except as otherwise provided in Q&A–3 of this section), any disposition of employer securities with respect to which the condition contained in provision (c) of Q&A–1 is met shall be treated, first, as a disposition of restricted qualified securities (on a first in, first out basis) and, thereafter, as a disposition of any other employer securities. Thus, for example, if a plan disposes of more employer securities than the number of restricted qualified securities held by the plan at that time and immediately after such disposition the value of the employer securities held by the plan is less than 30 percent of the total value of all outstanding employer securities, the portion of the total amount realized that is allocable to restricted qualified securities subject to tax under section 4978 is determined by multiplying the total amount realized on the disposition by a fraction, the numerator of which is the total value of restricted qualified securities included in the disposition and the denominator of which is the total value of employer securities in the disposition.

Q–3: What constitutes a ''disposition'' under section 4978?

A–3: (a) Under section 4978, the term ''disposition'' includes any sale, exchange, or distribution. However, in the case of any exchange of qualified securities for stock of another corporation in any reorganization described in section 368(a)(1), such exchange shall not be treated as a disposition for purposes of section 4978.

(b) Section 4978 shall not apply to any disposition of qualified securites which is made by reason of:

(1) The death of the employee;

(2) The retirement of the employee after the employee has attained 59½ years of age;

(3) The disability of the employee (within the meaning of section 72(m)(5)); or

(4) The separation of the employee from service for any period which results in a 1-year break in service (within the meaning of section 411(a)(6)(A)).

Any disposition of employer securities within this paragraph and any disposition of employer securities with respect to which the condition contained in provision (c) of Q&A–1 of this section is not met shall be treated, first, as a disposition of securities that are not restricted qualified securities and, thereafter, as a disposition of restricted qualified securities (on a first-in, first-out basis).

(c) If restricted qualified securities held by an employee stock ownership plan or eligible worker-owned cooperative no longer meet the definition of qualified securities (''old restricted qualified securities'') as a result of a transaction changing (1) the status of a corporation as an employer, or as a member of a controlled group of corporations including the employer, or (2) the existence of employer securities of the type described in section 409(l)(1), the disposition of such securities shall not be treated as a disposition of restricted qualified securites to

which the tax under section 4978 is imposed if, within 90 days after such disposition, securities meeting the requirements of section 409(l) (''new restricted qualified securities'') that are of equal value to the old restricted qualfied securities (at the time of the disposition of the old restricted qualified securities) are substituted for such old restricted qualified securities. However, for purposes of determining the tax imposed under section 4978, old restricted qualified securities shall not be treated as if they retained their status as restricted qualified securities and new restricted qualified securities derived from the disposition of old restricted qualified securities pursuant to the preceding sentence shall be treated as restricted qualified securities for the remaining portion of the period during which the disposition of the old restricted qualified securities would have been subject to tax under section 4978.

Q–4: To whom does the tax under section 4978 apply?

A–4: The tax under section 4978 is imposed on the domestic corporation (or corporations) or the eligible worker-owned cooperative that made the written statement of consent as described in section 1042(a)(2)(B) and Q&A–2 of §1.1042–1T with respect to the disposition of the restricted qualified securities.

Q–5: When does section 4978, as enacted by the Tax Reform Act of 1984, become effective?

A–5: Section 4978 applies to the disposition of qualified securities acquired in a sale to which section 1042 applies. See Q&A–6 of §1.1042–1T for the effective date of section 1042.

[T.D. 8073, 51 FR 4336, Feb. 4, 1986]

§ 54.4979–0 Excise tax on certain excess contributions and excess aggregate contributions; table of contents.

This section contains the captions that appear in §54.4979.

[T.D. 8357, 56 FR 40550, Aug. 15, 1991; 57 FR 10290, Mar. 25, 1992, as amended by T.D. 8581, 59 FR 66181, Dec. 23, 1994]

§ 54.4979–1 Excise tax on certain excess contributions and excess aggregate contributions.

(a) *In general*—(1) *General rule.* In the case of any plan (as defined in paragraph (b)(3) of this section), there is imposed a tax for the employer's taxable year equal to 10 percent of the sum of:

(i) Any excess contributions under a plan for the plan year ending in the taxable year; and

(ii) Any excess aggregate contributions under the plan for the plan year ending in the taxable year.

(2) *Liability for tax.* The tax imposed by paragraph (a)(1) of this section is to be paid by the employer. In the case of a collectively bargained plan to which section 413(b) applies, all employers who are parties to the collective bargaining agreement and whose employees are participants in the plan are jointly and severally liable for the tax.

(3) *Due date and form for payment of tax*—(i) The tax described in paragraph (a)(1) of this section is due on the last day of the 15th month after the close of the plan year to which the excess contributions or excess aggregate contributions relate.

(ii) An employer that owes the tax described in paragraph (a)(1) of this section must file the form prescribed by the Commissioner for the payment of the tax.

(4) *Special rule for simplified employee pensions*—(i) An employer that maintains a simplified employee pension (SEP) as defined in section 408(k) that accepts elective contributions is exempted from the tax of section 4979 and paragraph (a)(1) of this section if it notifies its employees of the fact and tax consequences of excess contributions within 2½ months following the plan year for which excess contributions are made. The notification must meet the standards of paragraph (a)(4)(ii) of this section.

(ii) The employer's notification to each affected employee of the excess SEP contributions must specifically state, in a manner calculated to be understood by the average plan participant: the amount of the excess contributions attributable to that employee's elective deferrals; the calendar year for which the excess contributions were made; that the excess contributions are includible in the affected employee's gross income for the specified calendar year; and that failure to withdraw the excess contributions and income attributable thereto by the due date (plus extensions) for filing the affected employee's tax return for the preceding calendar year may result in significant penalties.

(iii) If an employer does not notify its employees by the last day of the 12-month period following the year of excess SEP contributions, the SEP will no longer be considered to meet the requirements of section 408(k)(6).

(b) *Definitions.* The following is a list of terms and definitions to be used for purposes of section 4979 and this section:

(1) *Excess aggregate contributions.* The term ''excess aggregate contribution'' has the meaning set forth in §1.401(m)–1(f)(8) of this chapter. For purposes of determining excess aggregate contributions under an annuity contract described in section 403(b), the contract is treated as a plan described in section 401(a).

(2) *Excess contributions.* The term ''excess contributions'' has the meaning set forth in sections 401(k)(8)(B), 408(k)(6)(C)(ii), and 501(c)(18). See, e.g., §1.401(k)–1(g)(7) of this chapter.

(3) *Plan.* The term ''plan'' means:

(i) A plan described in section 401(a) that includes a trust exempt from tax under section 501(a);

(ii) Any annuity plan described in section 403(a);

(iii) Any annuity contract described in section 403(b);

(iv) A simplified employee pension of an employer that satisfies the requirements of section 408(k); and

(v) A plan described in section 501(c)(18).

The term includes any plan that at any time has been determined by the Secretary to be one of the types of plans described in this paragraph (b)(3).

(c) *No tax when excess distributed within 2½ months of close of year or additional employer contributions made*—(1) *General rule.* No tax is imposed under this section on any excess contribution or excess aggregate contribution, as the case may be, to the extent the contribution (together with any income allocable thereto) is corrected before the close of the first 2½ months of the following plan year. Qualified nonelective contributions and qualified matching contributions taken into account under §1.401(k)–1(b)(5) of this chapter or qualified nonelective contributions or elective contributions taken into account under §1.401(m)–1(b)(5) of this chapter for a plan year may permit a plan to avoid excess contributions or excess aggregate contributions, respectively, even if made after the close of the 2½ month period. See §1.401(k)–1(f)(1)(i) and (6)(i) of this chapter for methods to avoid excess contributions, and §1.401(m)–1(e)(1)(i) of this chapter for methods to avoid excess aggregate contributions.

(2) *Tax treatment of distributions.* See §1.401(k)–1(f)(3)(ii) and (4)(v) of this chapter for rules for determining the tax consequences to a participant of a distribution or recharacterization of excess contributions and income allocable thereto, including a special rule for de minimis distributions. See §1.401(m)–1(e)(3)(v) of this chapter for rules for determining the tax consequences to a participant of a distribution of excess aggregate contributions and income allocable thereto.

(3) *Income.* See §1.401(k)–1(f)(4)(ii) of this chapter for rules for determining

income allocable to excess contributions. See § 1.401(m)–1(e)(3)(ii) of this chapter for rules for determining income allocable to excess aggregate contributions.

(4) *Example.* The provisions of this paragraph (c) are illustrated by the following example.

Example. (i) Employer X maintains Plan Y, a calendar year profit-sharing plan that includes a qualified cash or deferred arrangement. Under the plan, failure to satisfy the actual deferral percentage test may only be corrected by distributing the excess contributions or making qualified nonelective contributions (QNECs).

(ii) On December 31, 1990, X determines that Y does not satisfy the actual deferral percentage test for the 1990 plan year, and that excess contributions for the year equal $5,000. On March 1, 1991, Y distributes $2,000 of these excess contributions. On May 30, 1991, X distributes another $2,000 of excess contributions. On December 17, 1991, X contributes QNECs for certain nonhighly compensated employees, thereby eliminating the remainder of the excess contributions for 1990.

(iii) X has incurred a tax liability under section 4979 for 1990 equal to 10 percent of the excess contributions that were in the plan as of December 31, 1990. However, this tax is not imposed on the $2,000 distributed on March 1, 1991, or the amount corrected by QNECs. X must pay an excise tax of $200, 10 percent of the $2,000 of excess contributions distributed after March 15, 1991. This tax must be paid by March 31, 1992.

(d) *Effective date*—(1) *General rule.* Except as provided in paragraphs (d)(2) through (4), this section is effective for plan years beginning after December 31, 1986.

(2) *Section 403(b) annuity contracts.* In the case of an annuity contract under section 403(b), this section applies to plan years beginning after December 31, 1988.

(3) *Collectively bargained plans and plans of state or local governments.* For plan years beginning before January 1, 1993, the provisions of this section do not apply to a collectively bargained plan that automatically satisfies the requirements of section 410(b). See §§ 1.401(a)(4)–1(c)(5) and 1.410(b)–2(b)(7) of this chapter. In the case of a plan (including a collectively bargained plan) maintained by a state or local government, the provisions of this section do not apply for plan years beginning before the later of January 1, 1996, or 90 days after the opening of the first legislative session beginning on or after January 1, 1996, of the governing body with authority to amend the plan, if that body does not meet continuously. For purposes of this paragraph (d)(3), the term *governing body with authority to amend the plan* means the legislature, board, commission, council, or other governing body with authority to amend the plan.

(4) *Plan years beginning before January 1, 1992.* For plan years beginning before January 1, 1992, a reasonable interpretation of the rules set forth in section 4979, as in effect during those years, may be relied upon in determining whether the excise tax is due for those years.

[T.D. 8357, 56 FR 40550, Aug. 15, 1991, as amended by T.D. 8581, 59 FR 66181, Dec. 23, 1994]

§ 54.4980B–0 Table of contents.

This section contains first a list of the section headings and then a list of the questions in each section in §§ 54.4980B–1 through 54.4980B–10.

LIST OF SECTIONS

LIST OF QUESTIONS

Q–2: In the case of a stock sale, what are the selling group, the acquired organization, and the buying group?

Q–3: In the case of an asset sale, what are the selling group and the buying group?

Q–4: Who is an M&A qualified beneficiary?

Q–5: In the case of a stock sale, is the sale a qualifying event with respect to a covered employee who is employed by the acquired organization before the sale and who continues to be employed by the acquired organization after the sale, or with respect to the spouse or dependent children of such a covered employee?

Q–6: In the case of an asset sale, is the sale a qualifying event with respect to a covered employee whose employment immediately before the sale was associated with the purchased assets, or with respect to the spouse or dependent children of such a covered employee who are covered under a group health plan of the selling group immediately before the sale?

Q–7: In a business reorganization, are the buying group and the selling group permitted to allocate by contract the responsibility to make COBRA continuation coverage available to M&A qualified beneficiaries?

Q–8: Which group health plan has the obligation to make COBRA continuation coverage available to M&A qualified beneficiaries in a business reorganization?

Q–9: Can the cessation of contributions by an employer to a multiemployer group health plan be a qualifying event?

Q–10: If an employer stops contributing to a multiemployer group health plan, does the multiemployer plan have the obligation to make COBRA continuation coverage available to a qualified beneficiary who was receiving coverage under the multiemployer plan on the day before the cessation of contributions and who is, or whose qualifying event occurred in connection with, a covered employee whose last employment prior to the qualifying event was with the employer that has stopped contributing to the multiemployer plan?

§ 54.4980B–10 Interaction of FMLA and COBRA.

Q–1: In what circumstances does a qualifying event occur if an employee does not return from leave taken under FMLA?

Q–2: If a qualifying event described in Q&A–1 of this section occurs, when does it occur, and how is the maximum coverage period measured?

Q–3: If an employee fails to pay the employee portion of premiums for coverage under a group health plan during FMLA leave or declines coverage under a group health plan during FMLA leave, does this affect the determination of whether or when the employee has experienced a qualifying event?

Q–4: Is the application of the rules in Q&A–1 through Q&A–3 of this section affected by a requirement of state or local law to provide a period of coverage longer than that required under FMLA?

Q–5: May COBRA continuation coverage be conditioned upon reimbursement of the premiums paid by the employer for coverage under a group health plan during FMLA leave?

[T.D. 8812, 64 FR 5173, Feb. 3, 1999, as amended by T.D. 8928, 66 FR 1848, Jan. 10, 2001]

§ 54.4980B–1 COBRA in general.

The COBRA continuation coverage requirements are described in general in the following questions-and-answers:

Q–1: What are the health care continuation coverage requirements contained in section 4980B of the Internal Revenue Code and in ERISA?

A–1: (a) Section 4980B provides generally that a group health plan must offer each qualified beneficiary who would otherwise lose coverage under the plan as a result of a qualifying event an opportunity to elect, within the election period, continuation coverage under the plan. The continuation coverage requirements were added to section 162 by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Public Law 99–272 (100 Stat. 222), and moved to section 4980B by the Technical and Miscellaneous Revenue Act of 1988, Public Law 100–647 (102 Stat. 3342). Continuation coverage required under section 4980B is referred to in §§ 54.4980B–1 through 54.4980B–10 as COBRA continuation coverage.

(b) COBRA also added parallel continuation coverage requirements to

Part 6 of Subtitle B of Title I of the Employee Retirement Income Security Act of 1974 (ERISA) (29 U.S.C. 1161–1168), which is administered by the U.S. Department of Labor. If a plan does not comply with the COBRA continuation coverage requirements, the Internal Revenue Code imposes an excise tax on the employer maintaining the plan (or on the plan itself), whereas ERISA gives certain parties—including qualified beneficiaries who are participants or beneficiaries within the meaning of Title I of ERISA, as well as the Department of Labor—the right to file a lawsuit to redress the noncompliance. The rules in §§ 54.4980B–1 through 54.4980B–10 apply for purposes of section 4980B and generally also for purposes of the COBRA continuation coverage requirements in Title I of ERISA. However, certain provisions of the COBRA continuation coverage requirements (such as the definitions of group health plan, employee, and employer) are not identical in the Internal Revenue Code and Title I of ERISA. In those cases in which the statutory language is not identical, the rules in §§ 54.4980B–1 through 54.4980B–10 nonetheless apply to the COBRA continuation coverage requirements of Title I of ERISA, except to the extent those rules are inconsistent with the statutory language of Title I of ERISA.

(c) A group health plan that is subject to section 4980B (or the parallel provisions under ERISA) is referred to as being subject to COBRA. (See Q&A–4 of § 54.4980B–2). A qualified beneficiary can be required to pay for COBRA continuation coverage. The term *qualified beneficiary* is defined in Q&A–1 of § 54.4980B–3. The term *qualifying event* is defined in Q&A–1 of § 54.4980B–4. COBRA continuation coverage is described in § 54.4980B–5. The election procedures are described in § 54.4980B–6. Duration of COBRA continuation coverage is addressed in § 54.4980B–7, and payment for COBRA continuation coverage is addressed in § 54.4980B–8. Section 54.4980B–9 contains special rules for how COBRA applies in connection with business reorganizations and employer withdrawals from a multiemployer plan, and § 54.4980B–10 addresses how COBRA applies for individuals who take leave under the Family and Medical Leave Act of 1993. Unless the context indicates otherwise, any reference in §§ 54.4980B–1 through 54.4980B–10 to COBRA refers to section 4980B (as amended) and to the parallel provisions of ERISA.

Q–2: What standard applies for topics not addressed in §§ 54.4980B–1 through 54.4980B-10?

A–2: For purposes of section 4980B, for topics relating to the COBRA continuation coverage requirements of section 4980B that are not addressed in §§ 54.4980B–1 through 54.4980B–10 (such as methods for calculating the applicable premium), plans and employers must operate in good faith compliance with a reasonable interpretation of the statutory requirements in section 4980B.

[T.D. 8812, 64 FR 5173, Feb 3, 1999; 64 FR 14382, Mar. 25, 1999, as amended by T.D. 8928, 66 FR 1849, Jan. 10, 2001]

§ 54.4980B–2 Plans that must comply.

The following questions-and-answers apply in determining which plans must comply with the COBRA continuation coverage requirements:

Q–1: For purposes of section 4980B, what is a group health plan?

A–1: (a) For purposes of section 4980B, a group health plan is a plan maintained by an employer or employee organization to provide health care to individuals who have an employment-related connection to the employer or employee organization or to their families. Individuals who have an employment-related connection to the employer or employee organization consist of employees, former employees, the employer, and others associated or formerly associated with the employer or employee organization in a business relationship (including members of a union who are not currently employees). Health care is provided under a plan whether provided directly or through insurance, reimbursement, or otherwise, and whether or not provided through an on-site facility (except as set forth in paragraph (d) of this Q&A–1), or through a cafeteria plan (as defined in section 125) or other flexible benefit arrangement. (See paragraphs (b) through (e) in Q&A–8 of this section for rules regarding the application of

the COBRA continuation coverage requirements to certain health flexible spending arrangements.) For purposes of this Q&A–1, insurance includes not only group insurance policies but also one or more individual insurance policies in any arrangement that involves the provision of health care to two or more employees. A plan maintained by an employer or employee organization is any plan of, or contributed to (directly or indirectly) by, an employer or employee organization. Thus, a group health plan is maintained by an employer or employee organization even if the employer or employee organization does not contribute to it if coverage under the plan would not be available at the same cost to an individual but for the individual's employment-related connection to the employer or employee organization. These rules are further explained in paragraphs (b) through (d) of this Q&A–1. An exception for qualified long-term care services is set forth in paragraph (e) of this Q&A–1, and for medical savings accounts in paragraph (f) of this Q&A–1. See Q&A–6 of this section for rules to determine the number of group health plans that an employer or employee organization maintains.

(b) For purposes of §§ 54.4980B–1 through 54.4980B–10, *health care* has the same meaning as *medical care* under section 213(d). Thus, health care generally includes the diagnosis, cure, mitigation, treatment, or prevention of disease, and any other undertaking for the purpose of affecting any structure or function of the body. Health care also includes transportation primarily for and essential to health care as described in the preceding sentence. However, health care does not include anything that is merely beneficial to the general health of an individual, such as a vacation. Thus, if an employer or employee organization maintains a program that furthers general good health, but the program does not relate to the relief or alleviation of health or medical problems and is generally accessible to and used by employees without regard to their physical condition or state of health, that program is not considered a program that provides health care and so is not a group health plan. For example, if an employer maintains a spa, swimming pool, gymnasium, or other exercise/fitness program or facility that is normally accessible to and used by employees for reasons other than relief of health or medical problems, such a facility does not constitute a program that provides health care and thus is not a group health plan. In contrast, if an employer maintains a drug or alcohol treatment program or a health clinic, or any other facility or program that is intended to relieve or alleviate a physical condition or health problem, the facility or program is considered to be the provision of health care and so is considered a group health plan.

(c) Whether a benefit provided to employees constitutes health care is not affected by whether the benefit is excludable from income under section 132 (relating to certain fringe benefits). For example, if a department store provides its employees discounted prices on all merchandise, including health care items such as drugs or eyeglasses, the mere fact that the discounted prices also apply to health care items will not cause the program to be a plan providing health care, so long as the discount program would normally be accessible to and used by employees without regard to health needs or physical condition. If, however, the employer maintaining the discount program is a health clinic, so that the program is used exclusively by employees with health or medical needs, the program is considered to be a plan providing health care and so is considered to be a group health plan.

(d) The provision of health care at a facility that is located on the premises of an employer or employee organization does not constitute a group health plan if—

(1) The health care consists primarily of first aid that is provided during the employer's working hours for treatment of a health condition, illness, or injury that occurs during those working hours;

(2) The health care is available only to current employees; and

(3) Employees are not charged for the use of the facility.

(e) A plan does not constitute a group health plan subject to COBRA if substantially all of the coverage provided

under the plan is for qualified long-term care services (as defined in section 7702B(c)). For this purpose, a plan is permitted to use any reasonable method in determining whether substantially all of the coverage provided under the plan is for qualified long-term care services.

(f) Under section 106(b)(5), amounts contributed by an employer to a medical savings account (as defined in section 220(d)) are not considered part of a group health plan subject to COBRA. Thus, a plan is not required to make COBRA continuation coverage available with respect to amounts contributed by an employer to a medical savings account. A high deductible health plan does not fail to be a group health plan subject to COBRA merely because it covers a medical savings account holder.

Q–2: For purposes of section 4980B, what is the employer?

A–2: (a) For purposes of section 4980B, employer refers to—

(1) A person for whom services are performed;

(2) Any other person that is a member of a group described in section 414(b), (c), (m), or (o) that includes a person described in paragraph (a)(1) of this Q&A–2; and

(3) Any successor of a person described in paragraph (a)(1) or (2) of this Q&A–2.

(b) An employer is a successor employer if it results from a consolidation, merger, or similar restructuring of the employer or if it is a mere continuation of the employer. See paragraph (c) in Q&A–8 of § 54.4980B–9 for rules describing the circumstances in which a purchaser of substantial assets is a successor employer to the employer selling the assets.

Q–3: What is a multiemployer plan?

A–3: For purposes of §§ 54.4980B–1 through 54.4980B–10, a multiemployer plan is a plan to which more than one employer is required to contribute, that is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer, and that satisfies such other requirements as the Secretary of Labor may prescribe by regulation. Whenever reference is made in §§ 54.4980B–1 through 54.4980B–10 to a plan of or maintained by an employer or employee organization, the reference includes a multiemployer plan.

Q–4: What group health plans are subject to COBRA?

A–4: (a) All group health plans are subject to COBRA except group health plans described in paragraph (b) of this Q&A–4. Group health plans described in paragraph (b) of this Q&A–4 are referred to in §§ 54.4980B–1 through 54.4980B–10 as excepted from COBRA.

(b) The following group health plans are excepted from COBRA—

(1) Small-employer plans (see Q&A–5 of this section);

(2) Church plans (within the meaning of section 414(e)); and

(3) Governmental plans (within the meaning of section 414(d)).

(c) The COBRA continuation coverage requirements generally do not apply to group health plans that are excepted from COBRA. However, a small-employer plan otherwise excepted from COBRA is nonetheless subject to COBRA with respect to qualified beneficiaries who experience a qualifying event during a period when the plan is not a small-employer plan (see paragraph (g) of Q&A–5 of this section).

(d) Although governmental plans are not subject to the COBRA continuation coverage requirements, group health plans maintained by state or local governments are generally subject to parallel continuation coverage requirements that were added by section 10003 of COBRA to the Public Health Service Act (42 U.S.C. 300bb–1 through 300bb–8), which is administered by the U.S. Department of Health and Human Services. Federal employees and their family members covered under the Federal Employees Health Benefit Program are covered by generally similar, but not parallel, temporary continuation of coverage provisions enacted by the Federal Employees Health Benefits Amendments Act of 1988. See 5 U.S.C. 8905a.

Q–5: What is a small-employer plan?

A–5: (a) Except in the case of a multiemployer plan, a *small-employer plan* is a group health plan maintained by an employer (within the meaning of Q&A–

2 of this section) that normally employed fewer than 20 employees (within the meaning of paragraph (c) of this Q&A–5) during the preceding calendar year. In the case of a multiemployer plan, a *small-employer plan* is a group health plan under which each of the employers contributing to the plan for a calendar year normally employed fewer than 20 employees during the preceding calendar year. See Q&A–6 of this section for rules to determine the number of plans that an employer or employee organization maintains. The rules of this paragraph (a) are illustrated in the following example:

Example. (i) Corporation *S* employs 12 employees, all of whom work and reside in the United States. *S* maintains a group health plan for its employees and their families. *S* is a wholly-owned subsidiary of *P*. In the previous calendar year, the controlled group of corporations including *P* and *S* employed more than 19 employees, although the only employees in the United States of the controlled group that includes *P* and *S* are the 12 employees of *S*.

(ii) Under §1.414(b)-1 of this chapter, foreign corporations are not excluded from membership in a controlled group of corporations. Consequently, the group health plan maintained by *S* is not a small-employer plan during the current calendar year because the controlled group including *S* normally employed at least 20 employees in the preceding calendar year.

(b) An employer is considered to have normally employed fewer than 20 employees during a particular calendar year if, and only if, it had fewer than 20 employees on at least 50 percent of its typical business days during that year.

(c) All full-time and part-time common law employees of an employer are taken into account in determining whether an employer had fewer than 20 employees; however, an individual who is not a common law employee of the employer is not taken into account. Thus, the following individuals are not counted as employees for purposes of this Q&A–5 even though they are referred to as employees for all other purposes of §§54.4980B–1 through 54.4980B–10—

(1) Self-employed individuals (within the meaning of section 401(c)(1));

(2) Independent contractors (and their employees and independent contractors); and

(3) Directors (in the case of a corporation).

(d) In determining the number of the employees of an employer, each full-time employee is counted as one employee and each part-time employee is counted as a fraction of an employee, determined in accordance with paragraph (e) of this Q&A–5.

(e) An employer may determine the number of its employees on a daily basis or a pay period basis. The basis used by the employer must be used with respect to all employees of the employer and must be used for the entire year for which the number of employees is being determined. If an employer determines the number of its employees on a daily basis, it must determine the actual number of full-time employees on each typical business day and the actual number of part-time employees and the hours worked by each of those part-time employees on each typical business day. Each full-time employee counts as one employee on each typical business day and each part-time employee counts as a fraction, with the numerator of the fraction equal to the number of hours worked by that employee and the denominator equal to the number of hours that must be worked on a typical business day in order to be considered a full-time employee. If an employer determines the number of its employees on a pay period basis, it must determine the actual number of full-time employees employed during that pay period and the actual number of part-time employees employed and the hours worked by each of those part-time employees during the pay period. For each day of that pay period, each full-time employee counts as one employee and each part-time employee counts as a fraction, with the numerator of the fraction equal to the number of hours worked by that employee during that pay period and the denominator equal to the number of hours that must be worked during that pay period in order to be considered a full-time employee. The determination of the number of hours required to be considered a full-time employee is based upon the employer's employment practices, except that in no event may the hours required to be considered a full-

time employee exceed eight hours for any day or 40 hours for any week.

(f) In the case of a multiemployer plan, the determination of whether the plan is a small-employer plan on any particular date depends on which employers are contributing to the plan on that date and on the workforce of those employers during the preceding calendar year. If a plan that is otherwise subject to COBRA ceases to be a small-employer plan because of the addition during a calendar year of an employer that did not normally employ fewer than 20 employees on a typical business day during the preceding calendar year, the plan ceases to be excepted from COBRA immediately upon the addition of the new employer. In contrast, if the plan ceases to be a small-employer plan by reason of an increase during a calendar year in the workforce of an employer contributing to the plan, the plan ceases to be excepted from COBRA on the January 1 immediately following the calendar year in which the employer's workforce increased.

(g) A small-employer plan is generally excepted from COBRA. If, however, a plan that has been subject to COBRA (that is, was not a small-employer plan) becomes a small-employer plan, the plan remains subject to COBRA for qualifying events that occurred during the period when the plan was subject to COBRA. The rules of this paragraph (g) are illustrated by the following examples:

Example 1. An employer maintains a group health plan. The employer employed 20 employees on more than 50 percent of its working days during 2001, and consequently the plan is not excepted from COBRA during 2002. Employee *E* resigns and does not work for the employer after January 31, 2002. Under the terms of the plan, *E* is no longer eligible for coverage upon the effective date of the resignation, that is, February 1, 2002. The employer does not hire a replacement for *E*. *E* timely elects and pays for COBRA continuation coverage. The employer employs 19 employees for the remainder of 2002, and consequently the plan is not subject to COBRA in 2003. The plan must nevertheless continue to make COBRA continuation coverage available to *E* during 2003 until the obligation to make COBRA continuation coverage available ceases under the rules of § 54.4980B–7. The obligation could continue until August 1, 2003, the date that is 18 months after the date of *E*'s qualifying event, or longer if *E* is eligible for a disability extension.

Example 2. The facts are the same as in *Example 1*. The employer continues to employ 19 employees throughout 2003 and 2004 and consequently the plan continues to be excepted from COBRA during 2004 and 2005. Spouse *S* is covered under the plan because *S* is married to one of the employer's employees. On April 1, 2002, *S* is divorced from that employee and ceases to be eligible for coverage under the plan. The plan is subject to COBRA during 2002 because *X* normally employed 20 employees during 2001. *S* timely notifies the plan administrator of the divorce and timely elects and pays for COBRA continuation coverage. Even though the plan is generally excepted from COBRA during 2003, 2004, and 2005, it must nevertheless continue to make COBRA continuation coverage available to *S* during those years until the obligation to make COBRA continuation coverage available ceases under the rules of § 54.4980B–7. The obligation could continue until April 1, 2005, the date that is 36 months after the date of *S*'s qualifying event.

Example 3. The facts are the same as in *Example 2*. *C* is a dependent child of one of the employer's employees and is covered under the plan. A dependent child is no longer eligible for coverage under the plan upon the attainment of age 23. *C* attains age 23 on November 16, 2005. The plan is excepted from COBRA with respect to *C* during 2005 because the employer normally employed fewer than 20 employees during 2004. Consequently, the plan is not obligated to make COBRA continuation coverage available to *C* (and would not be obligated to make COBRA continuation coverage available to *C* even if the plan later became subject to COBRA again).

Q–6: How is the number of group health plans that an employer or employee organization maintains determined?

A–6: (a) The rules of this Q&A–6 apply in determining the number of group health plans that an employer or employee organization maintains. All references elsewhere in §§ 54.4980B–1 through 54.4980B–10 to a group health plan are references to a group health plan as determined under Q&A–1 of this section and this Q&A–6. Except as provided in paragraph (b) or (c) of this Q&A–6, all health care benefits, other than benefits for qualified long-term care services (as defined in section 7702B(c)), provided by a corporation, partnership, or other entity or trade or

business, or by an employee organization, constitute one group health plan, unless—

(1) It is clear from the instruments governing an arrangement or arrangements to provide health care benefits that the benefits are being provided under separate plans; and

(2) The arrangement or arrangements are operated pursuant to such instruments as separate plans.

(b) A multiemployer plan and a nonmultiemployer plan are always separate plans.

(c) If a principal purpose of establishing separate plans is to evade any requirement of law, then the separate plans will be considered a single plan to the extent necessary to prevent the evasion.

(d) The significance of treating an arrangement as two or more separate group health plans is illustrated by the following examples:

Example 1. (i) Employer X maintains a single group health plan, which provides major medical and prescription drug benefits. Employer Y maintains two group health plans; one provides major medical benefits and the other provides prescription drug benefits.

(ii) *X*'s plan could comply with the COBRA continuation coverage requirements by giving a qualified beneficiary experiencing a qualifying event with respect to X's plan the choice of either electing both major medical and prescription drug benefits or not receiving any COBRA continuation coverage under X's plan. By contrast, for Y's plans to comply with the COBRA continuation coverage requirements, a qualified beneficiary experiencing a qualifying event with respect to each of Y's plans must be given the choice of electing COBRA continuation coverage under either the major medical plan or the prescription drug plan or both.

Example 2. If a joint board of trustees administers one multiemployer plan, that plan will fail to qualify for the small-employer plan exception if any one of the employers whose employees are covered under the plan normally employed 20 or more employees during the preceding calendar year. However, if the joint board of trustees maintains two or more multiemployer plans, then the exception would be available with respect to each of those plans in which each of the employers whose employees are covered under the plan normally employed fewer than 20 employees during the preceding calendar year.

Q–7: What is the plan year?

A–7: (a) The *plan year* is the year that is designated as the plan year in the plan documents.

(b) If the plan documents do not designate a plan year (or if there are no plan documents), then the plan year is determined in accordance with this paragraph (b).

(1) The plan year is the deductible/limit year used under the plan.

(2) If the plan does not impose deductibles or limits on an annual basis, then the plan year is the policy year.

(3) If the plan does not impose deductibles or limits on an annual basis, and either the plan is not insured or the insurance policy is not renewed on an annual basis, then the plan year is the employer's taxable year.

(4) In any other case, the plan year is the calendar year.

Q–8: How do the COBRA continuation coverage requirements apply to cafeteria plans and other flexible benefit arrangements?

A–8: (a)(1) The provision of health care benefits does not fail to be a group health plan merely because those benefits are offered under a cafeteria plan (as defined in section 125) or under any other arrangement under which an employee is offered a choice between health care benefits and other taxable or nontaxable benefits. However, the COBRA continuation coverage requirements apply only to the type and level of coverage under the cafeteria plan or other flexible benefit arrangement that a qualified beneficiary is actually receiving on the day before the qualifying event. See paragraphs (b) through (e) of this Q&A–8 for rules limiting the obligations of certain health flexible spending arrangements.

(2) The rules of this paragraph (a) are illustrated by the following example:

Example: (i) Under the terms of a cafeteria plan, employees can choose among life insurance coverage, membership in a health maintenance organization (HMO), coverage for medical expenses under an indemnity arrangement, and cash compensation. Of these available choices, the HMO and the indemnity arrangement are the arrangements providing health care. The instruments governing the HMO and indemnity arrangements indicate that they are separate group health plans. These group health plans are subject to COBRA. The employer does not

provide any group health plan outside of the cafeteria plan. *B* and *C* are unmarried employees. *B* has chosen the life insurance coverage, and *C* has chosen the indemnity arrangement.

(ii) *B* does not have to be offered COBRA continuation coverage upon terminating employment, nor is a subsequent open enrollment period for active employees required to be made available to *B*. However, if *C* terminates employment and the termination constitutes a qualifying event, *C* must be offered an opportunity to elect COBRA continuation coverage under the indemnity arrangement. If *C* makes such an election and an open enrollment period for active employees occurs while *C* is still receiving the COBRA continuation coverage, *C* must be offered the opportunity to switch from the indemnity arrangement to the HMO (but not to the life insurance coverage because that does not constitute coverage provided under a group health plan).

(b) If a health flexible spending arrangement (health FSA), within the meaning of section 106(c)(2), satisfies the two conditions in paragraph (c) of this Q&A–8 for a plan year, the obligation of the health FSA to make COBRA continuation coverage available to a qualified beneficiary who experiences a qualifying event in that plan year is limited in accordance with paragraphs (d) and (e) of this Q&A–8, as illustrated by an example in paragraph (f) of this Q&A–8. To the extent that a health FSA is obligated to make COBRA continuation coverage available to a qualified beneficiary, the health FSA must comply with all the applicable rules of §§ 54.4980B–1 through 54.4980B–10, including the rules of Q&A–3 in § 54.4980B–5 (relating to limits).

(c) The conditions of this paragraph (c) are satisfied if—

(1) Benefits provided under the health FSA are excepted benefits within the meaning of sections 9831 and 9832; and

(2) The maximum amount that the health FSA can require to be paid for a year of COBRA continuation coverage under Q&A–1 of § 54.4980B–8 equals or exceeds the maximum benefit available under the health FSA for the year.

(d) If the conditions in paragraph (c) of this Q&A–8 are satisfied for a plan year, then the health FSA is not obligated to make COBRA continuation coverage available for any subsequent plan year to any qualified beneficiary who experiences a qualifying event during that plan year.

(e) If the conditions in paragraph (c) of this Q&A–8 are satisfied for a plan year, the health FSA is not obligated to make COBRA continuation coverage available for that plan year to any qualified beneficiary who experiences a qualifying event during that plan year unless, as of the date of the qualifying event, the qualified beneficiary can become entitled to receive during the remainder of the plan year a benefit that exceeds the maximum amount that the health FSA is permitted to require to be paid for COBRA continuation coverage for the remainder of the plan year. In determining the amount of the benefit that a qualified beneficiary can become entitled to receive during the remainder of the plan year, the health FSA may deduct from the maximum benefit available to that qualified beneficiary for the year (based on the election made under the health FSA for that qualified beneficiary before the date of the qualifying event) any reimbursable claims submitted to the health FSA for that plan year before the date of the qualifying event.

(f) The rules of paragraphs (b), (c), (d), and (e) of this Q&A–8 are illustrated by the following example:

Example. (i) An employer maintains a group health plan providing major medical benefits and a group health plan that is a health FSA, and the plan year for each plan is the calendar year. Both the plan providing major medical benefits and the health FSA are subject to COBRA. Under the health FSA, during an open season before the beginning of each calendar year, employees can elect to reduce their compensation during the upcoming year by up to $1200 per year and have that same amount contributed to a health flexible spending account. The employer contributes an additional amount to the account equal to the employee's salary reduction election for the year. Thus, the maximum amount available to an employee under the health FSA for a year is two times the amount of the employee's salary reduction election for the year. This amount may be paid to the employee during the year as reimbursement for health expenses not covered by the employer's major medical plan (such as deductibles, copayments, prescription drugs, or eyeglasses). The employer determined, in accordance with section 4980B(f)(4), that a reasonable estimate of the cost of providing coverage for similarly situated nonCOBRA beneficiaries for 2002 under

this health FSA is equal to two times their salary reduction election for 2002 and, thus, that two times the salary reduction election is the applicable premium for 2002.

(ii) Because the employer provides major medical benefits under another group health plan, and because the maximum benefit that any employee can receive under the health FSA is not greater than two times the employee's salary reduction election for the plan year, benefits under this health FSA are excepted benefits within the meaning of sections 9831 and 9832. Thus, the first condition of paragraph (c) of this Q&A–8 is satisfied for the year. The maximum amount that a plan can require to be paid for coverage (outside of coverage required to be made available due to a disability extension) under Q&A–1 of § 54.4980B–8 is 102 percent of the applicable premium. Thus, the maximum amount that the health FSA can require to be paid for coverage for the 2002 plan year is 2.04 times the employee's salary reduction election for the plan year. Because the maximum benefit available under the health FSA is 2.0 times the employee's salary reduction election for the year, the maximum benefit available under the health FSA for the year is less than the maximum amount that the health FSA can require to be paid for coverage for the year. Thus, the second condition in paragraph (c) of this Q&A–8 is also satisfied for the 2002 plan year. Because both conditions in paragraph (c) of this Q&A–8 are satisfied for 2002, with respect to any qualifying event occurring in 2002, the health FSA is not obligated to make COBRA continuation coverage available for any year after 2002.

(iii) Whether the health FSA is obligated to make COBRA continuation coverage available in 2002 to a qualified beneficiary with respect to a qualifying event that occurs in 2002 depends upon the maximum benefit that would be available to the qualified beneficiary under COBRA continuation coverage for that plan year. *Case 1:* Employee *B* has elected to reduce *B*'s salary by $1200 for 2002. Thus, the maximum benefit that *B* can become entitled to receive under the health FSA during the entire year is $2400. *B* experiences a qualifying event that is the termination of *B*'s employment on May 31, 2002. As of that date, *B* had submitted $300 of reimbursable expenses under the health FSA. Thus, the maximum benefit that *B* could become entitled to receive for the remainder of 2002 is $2100. The maximum amount that the health FSA can require to be paid for COBRA continuation coverage for the remainder of 2002 is 102 percent times 1/12 of the applicable premium for 2002 times the number of months remaining in 2002 after the date of the qualifying event. In *B*'s case, the maximum amount that the health FSA can require to be paid for COBRA continuation coverage for 2002 is 2.04 times $1200, or $2448. One-twelfth of $2448 is $204. Because seven months remain in the plan year, the maximum amount that the health FSA can require to be paid for *B*'s coverage for the remainder of the year is seven times $204, or $1428. Because $1428 is less than the maximum benefit that *B* could become entitled to receive for the remainder of the year ($2100), the health FSA is required to make COBRA continuation coverage available to *B* for the remainder of 2002 (but not for any subsequent year).

(iv) *Case 2:* The facts are the same as in *Case 1* except that *B* had submitted $1000 of reimbursable expenses as of the date of the qualifying event. In that case, the maximum benefit available to *B* for the remainder of the year would be $1400 instead of $2100. Because the maximum amount that the health FSA can require to be paid for *B*'s coverage is $1428, and because the $1400 maximum benefit for the remainder of the year does not exceed $1428, the health FSA is not obligated to make COBRA continuation coverage available to *B* in 2002 (or any later year). (Of course, the administrator of the health FSA is permitted to make COBRA continuation coverage available to every qualified beneficiary in the year that the qualified beneficiary's qualifying event occurs in order to avoid having to determine the maximum benefit available for each qualified beneficiary for the remainder of the plan year.)

Q–9: What is the effect of a group health plan's failure to comply with the requirements of section 4980B(f)?

A–9: Under section 4980B(a), if a group health plan subject to COBRA fails to comply with section 4980B(f), an excise tax is imposed. Moreover, non-tax remedies may be available if the plan fails to comply with the parallel requirements in ERISA, which are administered by the Department of Labor.

Q–10: Who is liable for the excise tax if a group health plan fails to comply with the requirements of section 4980B(f)?

A–10: (a) In general, the excise tax is imposed on the employer maintaining the plan, except that in the case of a multiemployer plan (see Q&A–3 of this section for a definition of multiemployer plan) the excise tax is imposed on the plan.

(b) In certain circumstances, the excise tax is also imposed on a person involved with the provision of benefits under the plan (other than in the capacity of an employee), such as an insurer providing benefits under the plan

or a third party administrator administering claims under the plan. In general, such a person will be liable for the excise tax if the person assumes, under a legally enforceable written agreement, the responsibility for performing the act to which the failure to comply with the COBRA continuation coverage requirements relates. Such a person will be liable for the excise tax notwithstanding the absence of a written agreement assuming responsibility for complying with COBRA if the person provides coverage under the plan to a similarly situated nonCOBRA beneficiary (see Q&A–3 of § 54.4980B–3 for a definition of similarly situated nonCOBRA beneficiaries) and the employer or plan administrator submits a written request to the person to provide to a qualified beneficiary the same coverage that the person provides to the similarly situated nonCOBRA beneficiary. If the person providing coverage under the plan to a similarly situated nonCOBRA beneficiary is the plan administrator and the qualifying event is a divorce or legal separation or a dependent child's ceasing to be covered under the generally applicable requirements of the plan, the plan administrator will also be liable for the excise tax if the qualified beneficiary submits a written request for coverage.

[T.D. 8812, 64 FR 5174, Feb. 3, 1999, as amended by T.D. 8928, 66 FR 1849, Jan. 10, 2001]

§ 54.4980B–3 Qualified beneficiaries.

The determination of who is a qualified beneficiary, an employee, or a covered employee, and of who are the similarly situated nonCOBRA beneficiaries is addressed in the following questions-and-answers:

Q–1: Who is a qualified beneficiary?

A–1: (a)(1) Except as set forth in paragraphs (c) through (f) of this Q&A–1, a qualified beneficiary is—

(i) Any individual who, on the day before a qualifying event, is covered under a group health plan by virtue of being on that day either a covered employee, the spouse of a covered employee, or a dependent child of the covered employee; or

(ii) Any child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage.

(2) In the case of a qualifying event that is the bankruptcy of the employer, a covered employee who had retired on or before the date of substantial elimination of group health plan coverage is also a qualified beneficiary, as is any spouse, surviving spouse, or dependent child of such a covered employee if, on the day before the bankruptcy qualifying event, the spouse, surviving spouse, or dependent child is a beneficiary under the plan.

(3) In general, an individual (other than a child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage) who is not covered under a plan on the day before the qualifying event cannot be a qualified beneficiary with respect to that qualifying event, and the reason for the individual's lack of actual coverage (such as the individual's having declined participation in the plan or failed to satisfy the plan's conditions for participation) is not relevant for this purpose. However, if the individual is denied or not offered coverage under a plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law (such as the Americans with Disabilities Act, 42 U.S.C. 12101–12213, the special enrollment rules of section 9801, or the requirements of section 9802 prohibiting discrimination in eligibility to enroll in a group health plan based on health status), then, for purposes of §§ 54.4980B–1 through 54.4980B–10, the individual will be considered to have had the coverage that was wrongfully denied or not offered.

(4) Paragraph (b) of this Q&A–1 describes how certain family members are not qualified beneficiaries even if they become covered under the plan; paragraphs (c), (d), and (e) of this Q&A–1 place limits on the general rules of this paragraph (a) concerning who is a qualified beneficiary; paragraph (f) of this Q&A–1 provides when an individual who has been a qualified beneficiary ceases to be a qualified beneficiary; paragraph (g) of this Q&A–1 defines *placed for adoption*; and paragraph (h) of this Q&A–1 contains examples.

(b) In contrast to a child who is born to or placed for adoption with a covered employee during a period of

COBRA continuation coverage, an individual who marries any qualified beneficiary on or after the date of the qualifying event and a newborn or adopted child (other than one born to or placed for adoption with a covered employee) are not qualified beneficiaries by virtue of the marriage, birth, or placement for adoption or by virtue of the individual's status as the spouse or the child's status as a dependent of the qualified beneficiary. These new family members do not themselves become qualified beneficiaries even if they become covered under the plan. (For situations in which a plan is required to make coverage available to new family members of a qualified beneficiary who is receiving COBRA continuation coverage, see Q&A–5 of § 54.4980B–5, paragraph (c) in Q&A–4 of § 54.4980B–5, and section 9801(f)(2).)

(c) An individual is not a qualified beneficiary if, on the day before the qualifying event referred to in paragraph (a) of this Q&A–1, the individual is covered under the group health plan by reason of another individual's election of COBRA continuation coverage and is not already a qualified beneficiary by reason of a prior qualifying event.

(d) A covered employee can be a qualified beneficiary only in connection with a qualifying event that is the termination, or reduction of hours, of the covered employee's employment, or that is the bankruptcy of the employer.

(e) An individual is not a qualified beneficiary if the individual's status as a covered employee is attributable to a period in which the individual was a nonresident alien who received from the individual's employer no earned income (within the meaning of section 911(d)(2)) that constituted income from sources within the United States (within the meaning of section 861(a)(3)). If, pursuant to the preceding sentence, an individual is not a qualified beneficiary, then a spouse or dependent child of the individual is not considered a qualified beneficiary by virtue of the relationship to the individual.

(f) A qualified beneficiary who does not elect COBRA continuation coverage in connection with a qualifying event ceases to be a qualified beneficiary at the end of the election period (see Q&A–1 of § 54.4980B–6). Thus, for example, if such a former qualified beneficiary is later added to a covered employee's coverage (e.g., during an open enrollment period) and then another qualifying event occurs with respect to the covered employee, the former qualified beneficiary does not become a qualified beneficiary by reason of the second qualifying event. If a covered employee who is a qualified beneficiary does not elect COBRA continuation coverage during the election period, then any child born to or placed for adoption with the covered employee on or after the date of the qualifying event is not a qualified beneficiary. Once a plan's obligation to make COBRA continuation coverage available to an individual who has been a qualified beneficiary ceases under the rules of § 54.4980B–7, the individual ceases to be a qualified beneficiary.

(g) For purposes of §§ 54.4980B–1 through 54.4980B–10, *placement for adoption* or *being placed for adoption* means the assumption and retention by the covered employee of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement for adoption with the covered employee terminates upon the termination of the legal obligation for total or partial support. A child who is immediately adopted by the covered employee without a preceding placement for adoption is considered to be placed for adoption on the date of the adoption.

(h) The rules of this Q&A–1 are illustrated by the following examples:

Example 1. (i) *B* is a single employee who voluntarily terminates employment and elects COBRA continuation coverage under a group health plan. To comply with the requirements of section 9801(f), the plan permits a covered employee who marries to have her or his spouse covered under the plan. One month after electing COBRA continuation coverage, *B* marries and chooses to have *B*'s spouse covered under the plan.

(ii) *B*'s spouse is not a qualified beneficiary. Thus, if *B* dies during the period of COBRA continuation coverage, the plan does not have to offer *B*'s surviving spouse an opportunity to elect COBRA continuation coverage.

Example 2. (i) *C* is a married employee who terminates employment. *C* elects COBRA continuation coverage for *C* but not *C*'s

spouse, and *C*'s spouse declines to elect such coverage. *C*'s spouse thus ceases to be a qualified beneficiary. At the next open enrollment period, *C* adds the spouse as a beneficiary under the plan.

(ii) The addition of the spouse during the open enrollment period does not make the spouse a qualified beneficiary. The plan thus will not have to offer the spouse an opportunity to elect COBRA continuation coverage upon a later divorce from or death of *C*.

Example 3. (i) Under the terms of a group health plan, a covered employee's child, upon attaining age 19, ceases to be a dependent eligible for coverage.

(ii) At that time, the child must be offered an opportunity to elect COBRA continuation coverage. If the child elects COBRA continuation coverage, the child marries during the period of the COBRA continuation coverage, and the child's spouse becomes covered under the group health plan, the child's spouse is not a qualified beneficiary.

Example 4. (i) *D* is a single employee who, upon retirement, is given the opportunity to elect COBRA continuation coverage but declines it in favor of an alternative offer of 12 months of employer-paid retiree health benefits. At the end of the election period, *D* ceases to be a qualified beneficiary and will not have to be given another opportunity to elect COBRA continuation coverage (at the end of those 12 months or at any other time). *D* marries *E* during the period of retiree health coverage and, under the terms of that coverage, *E* becomes covered under the plan.

(ii) If a divorce from or death of *D* will result in *E*'s losing coverage, *E* will be a qualified beneficiary because *E*'s coverage under the plan on the day before the qualifying event (that is, the divorce or death) will have been by reason of *D*'s acceptance of 12 months of employer-paid coverage after the prior qualifying event (*D*'s retirement) rather than by reason of an election of COBRA continuation coverage.

Example 5. (i) The facts are the same as in *Example 4*, except that, under the terms of the plan, the divorce or death does not cause *E* to lose coverage so that *E* continues to be covered for the balance of the original 12-month period.

(ii) *E* does not have to be allowed to elect COBRA continuation coverage because the loss of coverage at the end of the 12-month period is not caused by the divorce or death, and thus the divorce or death does not constitute a qualifying event. See Q&A–1 of § 54.4980B–4.

Q–2: Who is an employee and who is a covered employee?

A–2: (a)(1) For purposes of §§ 54.4980B–1 through 54.4980B–10 (except for purposes of Q&A–5 in § 54.4980B–2, relating to the exception from COBRA for plans maintained by an employer with fewer than 20 employees), an *employee* is any individual who is eligible to be covered under a group health plan by virtue of the performance of services for the employer maintaining the plan or by virtue of membership in the employee organization maintaining the plan. Thus, for purposes of §§ 54.4980B–1 through 54.4980B–10 (except for purposes of Q&A–5 in § 54.4980B–2), the following individuals are employees if their relationship to the employer maintaining the plan makes them eligible to be covered under the plan—

(i) Self-employed individuals (within the meaning of section 401(c)(1));

(ii) Independent contractors (and their employees and independent contractors); and

(iii) Directors (in the case of a corporation).

(2) Similarly, whenever reference is made in §§ 54.4980B–1 through 54.4980B–10 (except in Q&A–5 of § 54.4980B–2) to an employment relationship (such as by referring to the termination of employment of an employee or to an employee's being employed by an employer), the reference includes the relationship of those individuals who are employees within the meaning of this paragraph (a). See paragraph (c) in Q&A–5 of § 54.4980B–2 for a narrower meaning of employee solely for purposes of Q&A–5 of § 54.4980B–2.

(b) For purposes of §§ 54.4980B–1 through 54.4980B–10, a *covered employee* is any individual who is (or was) provided coverage under a group health plan (other than a plan that is excepted from COBRA on the date of the qualifying event; see Q&A–4 of § 54.4980B–2) by virtue of being or having been an employee. For example, a retiree or former employee who is covered by a group health plan is a covered employee if the coverage results in whole or in part from her or his previous employment. An employee (or former employee) who is merely eligible for coverage under a group health plan is generally not a covered employee if the employee (or former employee) is not actually covered under the plan. In general, the reason for the employee's (or former employee's) lack of actual coverage (such as having declined participation in the plan or having failed

to satisfy the plan's conditions for participation) is not relevant for this purpose. However, if the employee (or former employee) is denied or not offered coverage under circumstances in which the denial or failure to offer constitutes a violation of applicable law (such as the Americans with Disabilities Act, 42 U.S.C. 12101 through 12213, the special enrollment rules of section 9801, or the requirements of section 9802 prohibiting discrimination in eligibility to enroll in a group health plan based on health status), then, for purposes of §§ 54.4980B–1 through 54.4980B–10, the employee (or former employee) will be considered to have had the coverage that was wrongfully denied or not offered.

Q–3: Who are the similarly situated nonCOBRA beneficiaries?

A–3: For purposes of §§ 54.4980B–1 through 54.4980B–10, *similarly situated nonCOBRA beneficiaries* means the group of covered employees, spouses of covered employees, or dependent children of covered employees receiving coverage under a group health plan maintained by the employer or employee organization who are receiving that coverage for a reason other than the rights provided under the COBRA continuation coverage requirements and who, based on all of the facts and circumstances, are most similarly situated to the situation of the qualified beneficiary immediately before the qualifying event.

[T.D. 8812, 64 FR 5176, Feb. 3, 1999, as amended by T.D. 8928, 66 FR 1852, Jan. 10, 2001]

§ 54.4980B–4 Qualifying events.

The determination of what constitutes a qualifying event is addressed in the following questions and answers:

Q–1: What is a qualifying event?

A–1: (a) A *qualifying event* is an event that satisfies paragraphs (b), (c), and (d) of this Q&A–1. Paragraph (e) of this Q&A–1 further explains a reduction of hours of employment, paragraph (f) of this Q&A–1 describes the treatment of children born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, and paragraph (g) of this Q&A–1 contains examples. See Q&A–1 through Q&A–3 of § 54.4980B–10 for special rules in the case of leave taken under the Family and Medical Leave Act of 1993 (29 U.S.C. 2601–2619).

(b) An event satisfies this paragraph (b) if the event is any of the following—

(1) The death of a covered employee;

(2) The termination (other than by reason of the employee's gross misconduct), or reduction of hours, of a covered employee's employment;

(3) The divorce or legal separation of a covered employee from the employee's spouse;

(4) A covered employee's becoming entitled to Medicare benefits under Title XVIII of the Social Security Act (42 U.S.C. 1395–1395ggg);

(5) A dependent child's ceasing to be a dependent child of a covered employee under the generally applicable requirements of the plan; or

(6) A proceeding in bankruptcy under Title 11 of the United States Code with respect to an employer from whose employment a covered employee retired at any time.

(c) An event satisfies this paragraph (c) if, under the terms of the group health plan, the event causes the covered employee, or the spouse or a dependent child of the covered employee, to lose coverage under the plan. For this purpose, to lose coverage means to cease to be covered under the same terms and conditions as in effect immediately before the qualifying event. Any increase in the premium or contribution that must be paid by a covered employee (or the spouse or dependent child of a covered employee) for coverage under a group health plan that results from the occurrence of one of the events listed in paragraph (b) of this Q&A–1 is a loss of coverage. In the case of an event that is the bankruptcy of the employer, lose coverage also means any substantial elimination of coverage under the plan, occurring within 12 months before or after the date the bankruptcy proceeding commences, for a covered employee who had retired on or before the date of the substantial elimination of group health plan coverage or for any spouse, surviving spouse, or dependent child of such a covered employee if, on the day before the bankruptcy qualifying event, the spouse, surviving spouse, or dependent child is a beneficiary under

the plan. For purposes of this paragraph (c), a loss of coverage need not occur immediately after the event, so long as the loss of coverage occurs before the end of the maximum coverage period (see Q&A–4 and Q&A–6 of § 54.4980B–7). However, if neither the covered employee nor the spouse or a dependent child of the covered employee loses coverage before the end of what would be the maximum coverage period, the event does not satisfy this paragraph (c). If coverage is reduced or eliminated in anticipation of an event (for example, an employer's eliminating an employee's coverage in anticipation of the termination of the employee's employment, or an employee's eliminating the coverage of the employee's spouse in anticipation of a divorce or legal separation), the reduction or elimination is disregarded in determining whether the event causes a loss of coverage.

(d) An event satisfies this paragraph (d) if it occurs while the plan is subject to COBRA. Thus, an event will not satisfy this paragraph (d) if it occurs while the plan is excepted from COBRA (see Q&A–4 of § 54.4980B–2). Even if the plan later becomes subject to COBRA, it is not required to make COBRA continuation coverage available to anyone whose coverage ends as a result of an event during a year in which the plan is excepted from COBRA. For example, if a group health plan is excepted from COBRA as a small-employer plan during the year 2001 (see Q&A–5 of § 54.4980B–2) and an employee terminates employment on December 31, 2001, the termination is not a qualifying event and the plan is not required to permit the employee to elect COBRA continuation coverage. This is the case even if the plan ceases to be a small-employer plan as of January 1, 2002. Also, the same result will follow even if the employee is given three months of coverage beyond December 31 (that is, through March of 2002), because there will be no qualifying event as of the termination of coverage in March. However, if the employee's spouse is initially provided with the three-month coverage through March 2002, but the spouse divorces the employee before the end of the three months and loses coverage as a result of the divorce, the divorce will constitute a qualifying event during 2002 and so entitle the spouse to elect COBRA continuation coverage. See Q&A–7 of § 54.4980B–7 regarding the maximum coverage period in such a case.

(e) A reduction of hours of a covered employee's employment occurs whenever there is a decrease in the hours that a covered employee is required to work or actually works, but only if the decrease is not accompanied by an immediate termination of employment. This is true regardless of whether the covered employee continues to perform services following the reduction of hours of employment. For example, an absence from work due to disability, a temporary layoff, or any other reason (other than due to leave that is FMLA leave; see § 54.4980B–10) is a reduction of hours of a covered employee's employment if there is not an immediate termination of employment. If a group health plan measures eligibility for the coverage of employees by the number of hours worked in a given time period, such as the preceding month or quarter, and an employee covered under the plan fails to work the minimum number of hours during that time period, the failure to work the minimum number of required hours is a reduction of hours of that covered employee's employment.

(f) The qualifying event of a qualified beneficiary who is a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage is the qualifying event giving rise to the period of COBRA continuation coverage during which the child is born or placed for adoption. If a second qualifying event has occurred before the child is born or placed for adoption (such as the death of the covered employee), then the second qualifying event also applies to the newborn or adopted child. See Q&A–6 of § 54.4980B–7.

(g) The rules of this Q&A–1 are illustrated by the following examples, in each of which the group health plan is subject to COBRA:

Example 1. (i) An employee who is covered by a group health plan terminates employment (other than by reason of the employee's gross misconduct) and, beginning with

the day after the last day of employment, is given 3 months of employer-paid coverage under the same terms and conditions as before that date. At the end of the three months, the coverage terminates.

(ii) The loss of coverage at the end of the three months results from the termination of employment and, thus, the termination of employment is a qualifying event.

Example 2. (i) An employee who is covered by a group health plan retires (which is a termination of employment other than by reason of the employee's gross misconduct) and, upon retirement, is required to pay an increased amount for the same group health coverage that the employee had before retirement.

(ii) The increase in the premium or contribution required for coverage is a loss of coverage under paragraph (c) of this Q&A–1 and, thus, the retirement is a qualifying event.

Example 3. (i) An employee and the employee's spouse are covered under an employer's group health plan. The employee retires and is given identical coverage for life. However, the plan provides that the spousal coverage will not be continued beyond six months unless a higher premium for the spouse is paid to the plan.

(ii) The requirement for the spouse to pay a higher premium at the end of the six months is a loss of coverage under paragraph (c) of this Q&A–1. Thus, the retirement is a qualifying event and the spouse must be given an opportunity to elect COBRA continuation coverage.

Example 4. (i) *F* is a covered employee who is married to *G*, and both are covered under a group health plan maintained by *F*'s employer. *F* and *G* are divorced. Under the terms of the plan, the divorce causes *G* to lose coverage. The divorce is a qualifying event, and *G* elects COBRA continuation coverage, remarries during the period of COBRA continuation coverage, and *G*'s new spouse becomes covered under the plan. (See Q&A–5 in §54.4980B–5, paragraph (c) in Q&A–4 of §54.4980B–5, and section 9801(f)(2).) *G* dies. Under the terms of the plan, the death causes *G*'s new spouse to lose coverage under the plan.

(ii) *G*'s death is not a qualifying event because *G* is not a covered employee.

Example 5. (i) An employer maintains a group health plan for both active employees and retired employees (and their families). The coverage for active employees and retired employees is identical, and the employer does not require retirees to pay more for coverage than active employees. The plan does not make COBRA continuation coverage available when an employee retires (and is not required to because the retired employee has not lost coverage under the plan). The employer amends the plan to eliminate coverage for retired employees effective January 1, 2002. On that date, several retired employees (and their spouses and dependent children) have been covered under the plan since their retirement for less than the maximum coverage period that would apply to them in connection with their retirement.

(ii) The elimination of retiree coverage under these circumstances is a deferred loss of coverage for those retirees (and their spouses and dependent children) under paragraph (c) of this Q&A–1 and, thus, the retirement is a qualifying event. The plan must make COBRA continuation coverage available to them for the balance of the maximum coverage period that applies to them in connection with the retirement.

Q–2: Are the facts surrounding a termination of employment (such as whether it was voluntary or involuntary) relevant in determining whether the termination of employment is a qualifying event?

A–2: Apart from facts constituting gross misconduct, the facts surrounding the termination or reduction of hours are irrelevant in determining whether a qualifying event has occurred. Thus, it does not matter whether the employee voluntarily terminated or was discharged. For example, a strike or a lockout is a termination or reduction of hours that constitutes a qualifying event if the strike or lockout results in a loss of coverage as described in paragraph (c) of Q&A–1 of this section. Similarly, a layoff that results in such a loss of coverage is a qualifying event.

[T.D. 8812, 64 FR 5178, Feb. 3, 1999, as amended by T.D. 8928, 66 FR 1852, Jan. 10, 2001]

§ 54.4980B–5 COBRA continuation coverage.

The following questions-and-answers address the requirements for coverage to constitute COBRA continuation coverage:

Q–1: What is COBRA continuation coverage?

A–1: (a) If a qualifying event occurs, each qualified beneficiary (other than a qualified beneficiary for whom the qualifying event will not result in any immediate or deferred loss of coverage) must be offered an opportunity to elect to receive the group health plan coverage that is provided to similarly situated nonCOBRA beneficiaries (ordinarily, the same coverage that the

qualified beneficiary had on the day before the qualifying event). See Q&A–3 of § 54.4980B–3 for the definition of similarly situated nonCOBRA beneficiaries. This coverage is COBRA continuation coverage. If coverage is modified for similarly situated nonCOBRA beneficiaries, then the coverage made available to qualified beneficiaries is modified in the same way. If the continuation coverage offered differs in any way from the coverage made available to similarly situated nonCOBRA beneficiaries, the coverage offered does not constitute COBRA continuation coverage and the group health plan is not in compliance with COBRA unless other coverage that does constitute COBRA continuation coverage is also offered. Any elimination or reduction of coverage in anticipation of an event described in paragraph (b) of Q&A–1 of § 54.4980B–4 is disregarded for purposes of this Q&A–1 and for purposes of any other reference in §§ 54.4980B–1 through 54.4980B–10 to coverage in effect immediately before (or on the day before) a qualifying event. COBRA continuation coverage must not be conditioned upon, or discriminate on the basis of lack of, evidence of insurability.

(b) In the case of a qualified beneficiary who is a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, the child is generally entitled to elect immediately to have the same coverage that dependent children of active employees receive under the benefit packages under which the covered employee has coverage at the time of the birth or placement for adoption. Such a child would be entitled to elect coverage different from that elected by the covered employee during the next available open enrollment period under the plan. See Q&A–4 of this section.

Q–2: What deductibles apply if COBRA continuation coverage is elected?

A–2: (a) Qualified beneficiaries electing COBRA continuation coverage generally are subject to the same deductibles as similarly situated nonCOBRA beneficiaries. If a qualified beneficiary's COBRA continuation coverage begins before the end of a period prescribed for accumulating amounts toward deductibles, the qualified beneficiary must retain credit for expenses incurred toward those deductibles before the beginning of COBRA continuation coverage as though the qualifying event had not occurred. The specific application of this rule depends on the type of deductible, as set forth in paragraphs (b) through (d) of this Q&A–2. Special rules are set forth in paragraph (e) of this Q&A–2, and examples appear in paragraph (f) of this Q&A–2.

(b) If a deductible is computed separately for each individual receiving coverage under the plan, each individual's remaining deductible amount (if any) on the date COBRA continuation coverage begins is equal to that individual's remaining deductible amount immediately before that date.

(c) If a deductible is computed on a family basis, the remaining deductible for the family on the date that COBRA continuation coverage begins depends on the members of the family electing COBRA continuation coverage. In computing the family deductible that remains on the date COBRA continuation coverage begins, only the expenses of those family members receiving COBRA continuation coverage need be taken into account. If the qualifying event results in there being more than one family unit (for example, because of a divorce), the family deductible may be computed separately for each resulting family unit based on the members in each unit. These rules apply regardless of whether the plan provides that the family deductible is an alternative to individual deductibles or an additional requirement.

(d) Deductibles that are not described in paragraph (b) or (c) of this Q&A–2 must be treated in a manner consistent with the principles set forth in those paragraphs.

(e) If a deductible is computed on the basis of a covered employee's compensation instead of being a fixed dollar amount and the employee remains employed during the period of COBRA continuation coverage, the plan is permitted to choose whether to apply the deductible by treating the employee's compensation as continuing without change for the duration of the COBRA continuation coverage at the level that was used to compute the deductible in

effect immediately before the COBRA continuation coverage began, or to apply the deductible by taking the employee's actual compensation into account. In applying a deductible that is computed on the basis of the covered employee's compensation instead of being a fixed dollar amount, for periods of COBRA continuation coverage in which the employee is not employed by the employer, the plan is required to compute the deductible by treating the employee's compensation as continuing without change for the duration of the COBRA continuation coverage either at the level that was used to compute the deductible in effect immediately before the COBRA continuation coverage began or at the level that was used to compute the deductible in effect immediately before the employee's employment was terminated.

(f) The rules of this Q&A–2 are illustrated by the following examples; in each example, deductibles under the plan are determined on a calendar year basis:

Example 1. (i) A group health plan applies a separate $100 annual deductible to each individual it covers. The plan provides that the spouse and dependent children of a covered employee will lose coverage on the last day of the month after the month of the covered employee's death. A covered employee dies on June 11, 2001. The spouse and the two dependent children elect COBRA continuation coverage, which will begin on August 1, 2001. As of July 31, 2001, the spouse has incurred $80 of covered expenses, the older child has incurred no covered expenses, and the younger one has incurred $120 of covered expenses (and therefore has already satisfied the deductible).

(ii) At the beginning of COBRA continuation coverage on August 1, the spouse has a remaining deductible of $20, the older child still has the full $100 deductible, and the younger one has no further deductible.

Example 2. (i) A group health plan applies a separate $200 annual deductible to each individual it covers, except that each family member is treated as having satisfied the individual deductible once the family has incurred $500 of covered expenses during the year. The plan provides that upon the divorce of a covered employee, coverage will end immediately for the employee's spouse and any children who do not remain in the employee's custody. A covered employee with four dependent children is divorced, the spouse obtains custody of the two oldest children, and the spouse and those children all elect COBRA continuation coverage to begin immediately. The family had accumulated $420 of covered expenses before the divorce, as follows: $70 by each parent, $200 by the oldest child, $80 by the youngest child, and none by the other two children.

(ii) The resulting family consisting of the spouse and the two oldest children accumulated a total of $270 of covered expenses, and thus the remaining deductible for that family could be as high as $230 (because the plan would not have to count the incurred expenses of the covered employee and the youngest child). The remaining deductible for the resulting family consisting of the covered employee and the two youngest children is not subject to the rules of this Q&A–2 because their coverage is not COBRA continuation coverage.

Example 3. Each year a group health plan pays 70 percent of the cost of an individual's psychotherapy after that individual's first three visits during the year. A qualified beneficiary whose election of COBRA continuation coverage takes effect beginning August 1, 2001 and who has already made two visits as of that date need only pay for one more visit before the plan must begin to pay 70 percent of the cost of the remaining visits during 2001.

Example 4. (i) A group health plan has a $250 annual deductible per covered individual. The plan provides that if the deductible is not satisfied in a particular year, expenses incurred during October through December of that year are credited toward satisfaction of the deductible in the next year. A qualified beneficiary who has incurred covered expenses of $150 from January through September of 2001 and $40 during October elects COBRA continuation coverage beginning November 1, 2001.

(ii) The remaining deductible amount for this qualified beneficiary is $60 at the beginning of the COBRA continuation coverage. If this individual incurs covered expenses of $50 in November and December of 2001 combined (so that the $250 deductible for 2001 is not satisfied), the $90 incurred from October through December of 2001 are credited toward satisfaction of the deductible amount for 2002.

Q–3: How do a plan's limits apply to COBRA continuation coverage?

A–3: (a) Limits are treated in the same way as deductibles (see Q&A–2 of this section). This rule applies both to limits on plan benefits (such as a maximum number of hospital days or dollar amount of reimbursable expenses) and limits on out-of-pocket expenses (such as a limit on copayments, a limit on deductibles plus copayments, or a catastrophic limit). This rule applies equally to annual and lifetime limits

and applies equally to limits on specific benefits and limits on benefits in the aggregate under the plan.

(b) The rule of this Q&A–3 is illustrated by the following examples; in each example limits are determined on a calendar year basis:

Example 1. (i) A group health plan pays for a maximum of 150 days of hospital confinement per individual per year. A covered employee who has had 20 days of hospital confinement as of May 1, 2001 terminates employment and elects COBRA continuation coverage as of that date.

(ii) During the remainder of the year 2001 the plan need only pay for a maximum of 130 days of hospital confinement for this individual.

Example 2. (i) A group health plan reimburses a maximum of $20,000 of covered expenses per family per year, and the same $20,000 limit applies to unmarried covered employees. A covered employee and spouse who have no children divorce on May 1, 2001, and the spouse elects COBRA continuation coverage as of that date. In 2001, the employee had incurred $5,000 of expenses and the spouse had incurred $8,000 before May 1.

(ii) The plan can limit its reimbursement of the amount of expenses incurred by the spouse on and after May 1 for the remainder of the year to $12,000 ($20,000 − $8,000 = $12,000). The remaining limit for the employee is not subject to the rules of this Q&A–3 because the employee's coverage is not COBRA continuation coverage.

Example 3. (i) A group health plan pays for 80 percent of covered expenses after satisfaction of a $100-per-individual deductible, and the plan pays for 100 percent of covered expenses after a family has incurred out-of-pocket costs of $2,000. The plan provides that upon the divorce of a covered employee, coverage will end immediately for the employee's spouse and any children who do not remain in the employee's custody. An employee and spouse with three dependent children divorce on June 1, 2001, and one of the children remains with the employee. The spouse elects COBRA continuation coverage as of that date for the spouse and the other two children. During January through May of 2001, the spouse incurred $600 of covered expenses and each of the two children in the spouse's custody after the divorce incurred covered expenses of $1,100. This resulted in total out-of-pocket costs for these three individuals of $800 ($300 total for the three deductibles, plus $500 for 20 percent of the other $2,500 in incurred expenses [$600 + $1,100 + $1,100 = $2,800; $2,800 − $300 = $2,500]).

(ii) For the remainder of 2001, the resulting family consisting of the spouse and two children has an out-of-pocket limit of $1,200 ($2,000 − $800 = $1,200) . The remaining out-of-pocket limit for the resulting family consisting of the employee and one child is not subject to the rules of this Q&A–3 because their coverage is not COBRA continuation coverage.

Q–4: Can a qualified beneficiary who elects COBRA continuation coverage ever change from the coverage received by that individual immediately before the qualifying event?

A–4: (a) In general, a qualified beneficiary need only be given an opportunity to continue the coverage that she or he was receiving immediately before the qualifying event. This is true regardless of whether the coverage received by the qualified beneficiary before the qualifying event ceases to be of value to the qualified beneficiary, such as in the case of a qualified beneficiary covered under a region-specific health maintenance organization (HMO) who leaves the HMO's service region. The only situations in which a qualified beneficiary must be allowed to change from the coverage received immediately before the qualifying event are as set forth in paragraphs (b) and (c) of this Q&A–4 and in Q&A–1 of this section (regarding changes to or elimination of the coverage provided to similarly situated nonCOBRA beneficiaries).

(b) If a qualified beneficiary participates in a region-specific benefit package (such as an HMO or an on-site clinic) that will not service her or his health needs in the area to which she or he is relocating (regardless of the reason for the relocation), the qualified beneficiary must be given, within a reasonable period after requesting other coverage, an opportunity to elect alternative coverage that the employer or employee organization makes available to active employees. If the employer or employee organization makes group health plan coverage available to similarly situated nonCOBRA beneficiaries that can be extended in the area to which the qualified beneficiary is relocating, then that coverage is the alternative coverage that must be made available to the relocating qualified beneficiary. If the employer or employee organization does not make group health plan coverage available to similarly situated nonCOBRA beneficiaries that can be extended in the

area to which the qualified beneficiary is relocating but makes coverage available to other employees that can be extended in that area, then the coverage made available to those other employees must be made available to the relocating qualified beneficiary. The effective date of the alternative coverage must be not later than the date of the qualified beneficiary's relocation, or, if later, the first day of the month following the month in which the qualified beneficiary requests the alternative coverage. However, the employer or employee organization is not required to make any other coverage available to the relocating qualified beneficiary if the only coverage the employer or employee organization makes available to active employees is not available in the area to which the qualified beneficiary relocates (because all such coverage is region-specific and does not service individuals in that area).

(c) If an employer or employee organization makes an open enrollment period available to similarly situated active employees with respect to whom a qualifying event has not occurred, the same open enrollment period rights must be made available to each qualified beneficiary receiving COBRA continuation coverage. An open enrollment period means a period during which an employee covered under a plan can choose to be covered under another group health plan or under another benefit package within the same plan, or to add or eliminate coverage of family members.

(d) The rules of this Q&A–4 are illustrated by the following examples:

Example 1. (i) *E* is an employee who works for an employer that maintains several group health plans. Under the terms of the plans, if an employee chooses to cover any family members under a plan, all family members must be covered by the same plan and that plan must be the same as the plan covering the employee. Immediately before *E*'s termination of employment (for reasons other than gross misconduct), *E* is covered along with *E*'s spouse and children by a plan. The coverage under that plan will end as a result of the termination of employment.

(ii) Upon *E*'s termination of employment, each of the four family members is a qualified beneficiary. Even though the employer maintains various other plans and options, it is not necessary for the qualified beneficiaries to be allowed to switch to a new plan when *E* terminates employment.

(iii) COBRA continuation coverage is elected for each of the four family members. Three months after *E*'s termination of employment there is an open enrollment period during which similarly situated active employees are offered an opportunity to choose to be covered under a new plan or to add or eliminate family coverage.

(iv) During the open enrollment period, each of the four qualified beneficiaries must be offered the opportunity to switch to another plan (as though each qualified beneficiary were an individual employee). For example, each member of *E*'s family could choose coverage under a separate plan, even though the family members of employed individuals could not choose coverage under separate plans. Of course, if each family member chooses COBRA continuation coverage under a separate plan, the plan can require payment for each family member that is based on the applicable premium for individual coverage under that separate plan. See Q&A–1 of § 54.4980B–8.

Example 2. (i) The facts are the same as in *Example 1*, except that *E*'s family members are not covered under *E*'s group health plan when *E* terminates employment.

(ii) Although the family members do not have to be given an opportunity to elect COBRA continuation coverage, *E* must be allowed to add them to *E*'s COBRA continuation coverage during the open enrollment period. This is true even though the family members are not, and cannot become, qualified beneficiaries (see Q&A–1 of § 54.4980B–3).

Q–5: Aside from open enrollment periods, can a qualified beneficiary who has elected COBRA continuation coverage choose to cover individuals (such as newborn children, adopted children, or new spouses) who join the qualified beneficiary's family on or after the date of the qualifying event?

A–5: (a) Yes. Under section 9801, employees eligible to participate in a group health plan (whether or not participating), as well as former employees participating in a plan (referred to in those rules as participants), are entitled to special enrollment rights for certain family members upon the loss of other group health plan coverage or upon the acquisition by the employee or participant of a new spouse or of a new dependent through birth, adoption, or placement for adoption, if certain requirements are satisfied. Employees not participating in the plan also can obtain rights for self-enrollment under

those rules. Once a qualified beneficiary is receiving COBRA continuation coverage (that is, has timely elected and made timely payment for COBRA continuation coverage), the qualified beneficiary has the same right to enroll family members under those special enrollment rules as if the qualified beneficiary were an employee or participant within the meaning of those rules. However, neither a qualified beneficiary who is not receiving COBRA continuation coverage nor a former qualified beneficiary has any special enrollment rights under those rules.

(b) In addition to the special enrollment rights described in paragraph (a) of this Q&A–5, if the plan covering the qualified beneficiary provides that new family members of active employees can become covered (either automatically or upon an appropriate election) before the next open enrollment period, then the same right must be extended to the new family members of a qualified beneficiary.

(c) If the addition of a new family member will result in a higher applicable premium (for example, if the qualified beneficiary was previously receiving COBRA continuation coverage as an individual, or if the applicable premium for family coverage depends on family size), the plan can require the payment of a correspondingly higher amount for the COBRA continuation coverage. See Q&A–1 of § 54.4980B–8.

(d) The right to add new family members under this Q&A–5 is in addition to the rights that newborn and adopted children of covered employees may have as qualified beneficiaries; see Q&A–1 in § 54.4980B–3.

[T.D. 8812, 64 FR 5180, Feb. 3, 1999, as amended by T.D. 8928, 66 FR 1852, Jan. 10, 2001]

§ 54.4980B–6 Electing COBRA continuation coverage.

The following questions-and-answers address the manner in which COBRA continuation coverage is elected:

Q–1: What is the election period and how long must it last?

A–1: (a) A group health plan can condition the availability of COBRA continuation coverage upon the timely election of such coverage. An election of COBRA continuation coverage is a timely election if it is made during the election period. The election period must begin not later than the date the qualified beneficiary would lose coverage on account of the qualifying event. (See paragraph (c) of Q&A–1 of § 54.4980B–4 for the meaning of *lose coverage*.) The election period must not end before the date that is 60 days after the later of—

(1) The date the qualified beneficiary would lose coverage on account of the qualifying event; or

(2) The date notice is provided to the qualified beneficiary of her or his right to elect COBRA continuation coverage.

(b) An election is considered to be made on the date it is sent to the plan administrator.

(c) The rules of this Q&A–1 are illustrated by the following example:

Example. (i) An unmarried employee without children who is receiving employer-paid coverage under a group health plan voluntarily terminates employment on June 1, 2001. The employee is not disabled at the time of the termination of employment nor at any time thereafter, and the plan does not provide for the extension of the required periods (as is permitted under paragraph (b) of Q&A–4 of § 54.4980B–7).

(ii) *Case 1:* If the plan provides that the employer-paid coverage ends immediately upon the termination of employment, the election period must begin not later than June 1, 2001, and must not end earlier than July 31, 2001. If notice of the right to elect COBRA continuation coverage is not provided to the employee until June 15, 2001, the election period must not end earlier than August 14, 2001.

(iii) *Case 2:* If the plan provides that the employer-paid coverage does not end until 6 months after the termination of employment, the employee does not lose coverage until December 1, 2001. The election period can therefore begin as late as December 1, 2001, and must not end before January 30, 2002.

(iv) *Case 3:* If employer-paid coverage for 6 months after the termination of employment is offered only to those qualified beneficiaries who waive COBRA continuation coverage, the employee loses coverage on June 1, 2001, so the election period is the same as in Case 1. The difference between Case 2 and Case 3 is that in Case 2 the employee can receive 6 months of employer-paid coverage and then elect to pay for up to an additional 12 months of COBRA continuation coverage, while in Case 3 the employee must choose between 6 months of employer-paid coverage and paying for up to 18 months of COBRA continuation coverage. In all three cases, COBRA continuation coverage

need not be provided for more than 18 months after the termination of employment (see Q&A–4 of § 54.4980B–7), and in certain circumstances might be provided for a shorter period (see Q&A–1 of § 54.4980B–7).

Q–2: Is a covered employee or qualified beneficiary responsible for informing the plan administrator of the occurrence of a qualifying event?

A–2: (a) In general, the employer or plan administrator must determine when a qualifying event has occurred. However, each covered employee or qualified beneficiary is responsible for notifying the plan administrator of the occurrence of a qualifying event that is either a dependent child's ceasing to be a dependent child under the generally applicable requirements of the plan or a divorce or legal separation of a covered employee. The group health plan is not required to offer the qualified beneficiary an opportunity to elect COBRA continuation coverage if the notice is not provided to the plan administrator within 60 days after the later of—

(1) The date of the qualifying event; or

(2) The date the qualified beneficiary would lose coverage on account of the qualifying event.

(b) For purposes of this Q&A–2, if more than one qualified beneficiary would lose coverage on account of a divorce or legal separation of a covered employee, a timely notice of the divorce or legal separation that is provided by the covered employee or any one of those qualified beneficiaries will be sufficient to preserve the election rights of all of the qualified beneficiaries.

Q–3: During the election period and before the qualified beneficiary has made an election, must coverage be provided?

A–3: (a) In general, each qualified beneficiary has until 60 days after the later of the date the qualifying event would cause her or him to lose coverage or the date notice is provided to the qualified beneficiary of her or his right to elect COBRA continuation coverage to decide whether to elect COBRA continuation coverage. If the election is made during that period, coverage must be provided from the date that coverage would otherwise have been lost (but see Q&A–4 of this section). This can be accomplished as described in paragraph (b) or (c) of this Q&A–3.

(b) In the case of an indemnity or reimbursement arrangement, the employer or employee organization can provide for plan coverage during the election period or, if the plan allows retroactive reinstatement, the employer or employee organization can terminate the coverage of the qualified beneficiary and reinstate her or him when the election (and, if applicable, payment for the coverage) is made. Claims incurred by a qualified beneficiary during the election period do not have to be paid before the election (and, if applicable, payment for the coverage) is made. If a provider of health care (such as a physician, hospital, or pharmacy) contacts the plan to confirm coverage of a qualified beneficiary during the election period, the plan must give a complete response to the health care provider about the qualified beneficiary's COBRA continuation coverage rights during the election period. For example, if the plan provides coverage during the election period but cancels coverage retroactively if COBRA continuation coverage is not elected, then the plan must inform a provider that a qualified beneficiary for whom coverage has not been elected is covered but that the coverage is subject to retroactive termination. Similarly, if the plan cancels coverage but then retroactively reinstates it once COBRA continuation coverage is elected, then the plan must inform the provider that the qualified beneficiary currently does not have coverage but will have coverage retroactively to the date coverage was lost if COBRA continuation coverage is elected. (See paragraph (c) of Q&A–5 in § 54.4980B–8 for similar rules that a plan must follow in confirming coverage during a period when the plan has not received payment but that is still within the grace period for a qualified beneficiary for whom COBRA continuation coverage has been elected.)

(c)(1) In the case of a group health plan that provides health services (such as a health maintenance organization or a walk-in clinic), the plan can

require with respect to a qualified beneficiary who has not elected and paid for COBRA continuation coverage that the qualified beneficiary choose between—

(i) Electing and paying for the coverage; or

(ii) Paying the reasonable and customary charge for the plan's services, but only if a qualified beneficiary who chooses to pay for the services will be reimbursed for that payment within 30 days after the election of COBRA continuation coverage (and, if applicable, the payment of any balance due for the coverage).

(2) In the alternative, the plan can provide continued coverage and treat the qualified beneficiary's use of the facility as a constructive election. In such a case, the qualified beneficiary is obligated to pay any applicable charge for the coverage, but only if the qualified beneficiary is informed that use of the facility will be a constructive election before using the facility.

Q–4: Is a waiver before the end of the election period effective to end a qualified beneficiary's election rights?

A–4: If, during the election period, a qualified beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver of COBRA continuation coverage is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the employer, employee organization, or plan administrator, as applicable.

Q–5: Can an employer or employee organization withhold money or other benefits owed to a qualified beneficiary until the qualified beneficiary either waives COBRA continuation coverage, elects and pays for such coverage, or allows the election period to expire?

A–5: No. An employer, and an employee organization, must not withhold anything to which a qualified beneficiary is otherwise entitled (by operation of law or other agreement) in order to compel payment for COBRA continuation coverage or to coerce the qualified beneficiary to give up rights to COBRA continuation coverage (including the right to use the full election period to decide whether to elect such coverage). Such a withholding constitutes a failure to comply with the COBRA continuation coverage requirements. Furthermore, any purported waiver obtained by means of such a withholding is invalid.

Q–6: Can each qualified beneficiary make an independent election under COBRA?

A–6: Yes. Each qualified beneficiary (including a child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage. If the plan allows similarly situated active employees with respect to whom a qualifying event has not occurred to choose among several options during an open enrollment period (for example, to switch to another group health plan or to another benefit package under the same group health plan), then each qualified beneficiary must also be offered an independent election to choose during an open enrollment period among the options made available to similarly situated active employees with respect to whom a qualifying event has not occurred. If a qualified beneficiary who is either a covered employee or the spouse of a covered employee elects COBRA continuation coverage and the election does not specify whether the election is for self-only coverage, the election is deemed to include an election of COBRA continuation coverage on behalf of all other qualified beneficiaries with respect to that qualifying event. An election on behalf of a minor child can be made by the child's parent or legal guardian. An election on behalf of a qualified beneficiary who is incapacitated or dies can be made by the legal representative of the qualified beneficiary or the qualified beneficiary's estate, as determined under applicable state law, or by the spouse of the qualified beneficiary. (See also Q&A–5 of § 54.4980B–7 relating to the independent right of each qualified beneficiary with respect to the same qualifying event to receive COBRA continuation coverage

during the disability extension.) The rules of this Q&A–6 are illustrated by the following examples; in each example each group health plan is subject to COBRA:

Example 1. (i) Employee *H* and *H*'s spouse are covered under a group health plan immediately before *H*'s termination of employment (for reasons other than gross misconduct). Coverage under the plan will end as a result of the termination of employment.

(ii) Upon *H*'s termination of employment, both *H* and *H*'s spouse are qualified beneficiaries and each must be allowed to elect COBRA continuation coverage. Thus, *H* might elect COBRA continuation coverage while the spouse declines to elect such coverage, or *H* might elect COBRA continuation coverage for both of them. In contrast, *H* cannot decline COBRA continuation coverage on behalf of *H*'s spouse. Thus, if *H* does not elect COBRA continuation coverage on behalf of the spouse, the spouse must still be allowed to elect COBRA continuation coverage.

Example 2. (i) An employer maintains a group health plan under which all employees receive employer-paid coverage. Employees can arrange to cover their families by paying an additional amount. The employer also maintains a cafeteria plan, under which one of the options is to pay part or all of the employee share of the cost for family coverage under the group health plan. Thus, an employee might pay for family coverage under the group health plan partly with before-tax dollars and partly with after-tax dollars.

(ii) If an employee's family is receiving coverage under the group health plan when a qualifying event occurs, each of the qualified beneficiaries must be offered an opportunity to elect COBRA continuation coverage, regardless of how that qualified beneficiary's coverage was paid for before the qualifying event.

[T.D. 8812, 64 FR 5182, Feb. 3, 1999, as amended by T.D. 8928, 66 FR 1853, Jan. 10, 2001]

§ 54.4980B–7 Duration of COBRA continuation coverage.

The following questions-and-answers address the duration of COBRA continuation coverage:

Q–1: How long must COBRA continuation coverage be made available to a qualified beneficiary?

A–1: (a) Except for an interruption of coverage in connection with a waiver, as described in Q&A–4 of § 54.4980B–6, COBRA continuation coverage that has been elected for a qualified beneficiary must extend for at least the period beginning on the date of the qualifying event and ending not before the earliest of the following dates —

(1) The last day of the maximum coverage period (see Q&A–4 of this section);

(2) The first day for which timely payment is not made to the plan with respect to the qualified beneficiary (see Q&A–5 in § 54.4980B–8);

(3) The date upon which the employer or employee organization ceases to provide any group health plan (including successor plans) to any employee;

(4) The date, after the date of the election, upon which the qualified beneficiary first becomes covered under any other group health plan, as described in Q&A–2 of this section;

(5) The date, after the date of the election, upon which the qualified beneficiary first becomes entitled to Medicare benefits, as described in Q&A–3 of this section; and

(6) In the case of a qualified beneficiary entitled to a disability extension (see Q&A–5 of this section), the later of —

(i) Either 29 months after the date of the qualifying event, or the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act (42 U.S.C. 401–433 or 1381–1385) that the disabled qualified beneficiary whose disability resulted in the qualified beneficiary's being entitled to the disability extension is no longer disabled, whichever is earlier; or

(ii) The end of the maximum coverage period that applies to the qualified beneficiary without regard to the disability extension.

(b) However, a group health plan can terminate for cause the coverage of a qualified beneficiary receiving COBRA continuation coverage on the same basis that the plan terminates for cause the coverage of similarly situated nonCOBRA beneficiaries. For example, if a group health plan terminates the coverage of active employees for the submission of a fraudulent claim, then the coverage of a qualified beneficiary can also be terminated for the submission of a fraudulent claim. Notwithstanding the preceding two sentences, the coverage of a qualified

beneficiary can be terminated for failure to make timely payment to the plan only if payment is not timely under the rules of Q&A–5 in §54.4980B–8.

(c) In the case of an individual who is not a qualified beneficiary and who is receiving coverage under a group health plan solely because of the individual's relationship to a qualified beneficiary, if the plan's obligation to make COBRA continuation coverage available to the qualified beneficiary ceases under this section, the plan is not obligated to make coverage available to the individual who is not a qualified beneficiary.

Q–2: When may a plan terminate a qualified beneficiary's COBRA continuation coverage due to coverage under another group health plan?

A–2: (a) If a qualified beneficiary first becomes covered under another group health plan (including for this purpose any group health plan of a governmental employer or employee organization) after the date on which COBRA continuation coverage is elected for the qualified beneficiary and the other coverage satisfies the requirements of paragraphs (b), (c), and (d) of this Q&A–2, then the plan may terminate the qualified beneficiary's COBRA continuation coverage upon the date on which the qualified beneficiary first becomes covered under the other group health plan (even if the other coverage is less valuable to the qualified beneficiary). By contrast, if a qualified beneficiary first becomes covered under another group health plan on or before the date on which COBRA continuation coverage is elected, then the other coverage cannot be a basis for terminating the qualified beneficiary's COBRA continuation coverage.

(b) The requirement of this paragraph (b) is satisfied if the qualified beneficiary is actually covered, rather than merely eligible to be covered, under the other group health plan.

(c) The requirement of this paragraph (c) is satisfied if the other group health plan is a plan that is not maintained by the employer or employee organization that maintains the plan under which COBRA continuation coverage must otherwise be made available.

(d) The requirement of this paragraph (d) is satisfied if the other group health plan does not contain any exclusion or limitation with respect to any preexisting condition of the qualified beneficiary (other than such an exclusion or limitation that does not apply to, or is satisfied by, the qualified beneficiary by reason of the provisions in section 9801 (relating to limitations on preexisting condition exclusion periods in group health plans)).

(e) The rules of this Q&A–2 are illustrated by the following examples:

Example 1. (i) Employer *X* maintains a group health plan subject to COBRA. *C* is an employee covered under the plan. *C* is also covered under a group health plan maintained by Employer *Y*, the employer of *C*'s spouse. *C* terminates employment (for reasons other than gross misconduct), and the termination of employment causes *C* to lose coverage under *X*'s plan (and, thus, is a qualifying event). *C* elects to receive COBRA continuation coverage under *X*'s plan.

(ii) Under these facts, *X*'s plan cannot terminate *C*'s COBRA continuation coverage on the basis of *C*'s coverage under *Y*'s plan.

Example 2. (i) Employer *W* maintains a group health plan subject to COBRA. *D* is an employee covered under the plan. *D* terminates employment (for reasons other than gross misconduct), and the termination of employment causes *D* to lose coverage under *W*'s plan (and, thus, is a qualifying event). *D* elects to receive COBRA continuation coverage under *W*'s plan. Later *D* becomes employed by Employer *V* and is covered under *V*'s group health plan. *D*'s coverage under *V*'s plan is not subject to any exclusion or limitation with respect to any preexisting condition of *D*.

(ii) Under these facts, *W* can terminate *D*'s COBRA continuation coverage on the date *D* becomes covered under *V*'s plan.

Example 3. (i) The facts are the same as in *Example 2*, except that *D* becomes employed by *V* and becomes covered under *V*'s group health plan before *D* elects COBRA continuation coverage under *W*'s plan.

(ii) Because the termination of employment is a qualifying event, *D* must be offered COBRA continuation coverage under *W*'s plan, and *W* is not permitted to terminate *D*'s COBRA continuation coverage on account of *D*'s coverage under *V*'s plan because *D* first became covered under *V*'s plan before COBRA continuation coverage was elected for *D*.

Q–3: When may a plan terminate a qualified beneficiary's COBRA continuation coverage due to the qualified

beneficiary's entitlement to Medicare benefits?

A–3: (a) If a qualified beneficiary first becomes entitled to Medicare benefits under Title XVIII of the Social Security Act (42 U.S.C. 1395–1395ggg) after the date on which COBRA continuation coverage is elected for the qualified beneficiary, then the plan may terminate the qualified beneficiary's COBRA continuation coverage upon the date on which the qualified beneficiary becomes so entitled. By contrast, if a qualified beneficiary first becomes entitled to Medicare benefits on or before the date that COBRA continuation coverage is elected, then the qualified beneficiary's entitlement to Medicare benefits cannot be a basis for terminating the qualified beneficiary's COBRA continuation coverage.

(b) A qualified beneficiary becomes entitled to Medicare benefits upon the effective date of enrollment in either part A or B, whichever occurs earlier. Thus, merely being eligible to enroll in Medicare does not constitute being entitled to Medicare benefits.

Q–4: When does the maximum coverage period end?

A–4: (a) Except as otherwise provided in this Q&A–4, the maximum coverage period ends 36 months after the qualifying event. The maximum coverage period for a qualified beneficiary who is a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage is the maximum coverage period for the qualifying event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption. Paragraph (b) of this Q&A–4 describes the starting point from which the end of the maximum coverage period is measured. The date that the maximum coverage period ends is described in paragraph (c) of this Q&A–4 in a case where the qualifying event is a termination of employment or reduction of hours of employment, in paragraph (d) of this Q&A–4 in a case where a covered employee becomes entitled to Medicare benefits under Title XVIII of the Social Security Act (42 U.S.C. 1395–1395ggg) before experiencing a qualifying event that is a termination of employment or reduction of hours of employment, and in paragraph (e) of this Q&A–4 in the case of a qualifying event that is the bankruptcy of the employer. See Q&A–8 of § 54.4980B–2 for limitations that apply to certain health flexible spending arrangements. See also Q&A–6 of this section in the case of multiple qualifying events. Nothing in §§ 54.4980B–1 through 54.4980B–10 prohibits a group health plan from providing coverage that continues beyond the end of the maximum coverage period.

(b)(1) The end of the maximum coverage period is measured from the date of the qualifying event even if the qualifying event does not result in a loss of coverage under the plan until a later date. If, however, coverage under the plan is lost at a later date and the plan provides for the extension of the required periods, then the maximum coverage period is measured from the date when coverage is lost. A plan provides for the extension of the required periods if it provides both—

(i) That the 30-day notice period (during which the employer is required to notify the plan administrator of the occurrence of certain qualifying events such as the death of the covered employee or the termination of employment or reduction of hours of employment of the covered employee) begins on the date of the loss of coverage rather than on the date of the qualifying event; and

(ii) That the end of the maximum coverage period is measured from the date of the loss of coverage rather than from the date of the qualifying event.

(2) In the case of a plan that provides for the extension of the required periods, whenever the rules of §§ 54.4980B–1 through 54.4980B–10 refer to the measurement of a period from the date of the qualifying event, those rules apply in such a case by measuring the period instead from the date of the loss of coverage.

(c) In the case of a qualifying event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the qualifying event if there is no disability extension, and 29 months after the qualifying event if there is a disability extension. See

Q&A–5 of this section for rules to determine if there is a disability extension. If there is a disability extension and the disabled qualified beneficiary is later determined to no longer be disabled, then a plan may terminate the COBRA continuation coverage of an affected qualified beneficiary before the end of the disability extension; see paragraph (a)(6) in Q&A–1 of this section.

(d)(1) If a covered employee becomes entitled to Medicare benefits under Title XVIII of the Social Security Act (42 U.S.C. 1395–1395ggg) before experiencing a qualifying event that is a termination of employment or reduction of hours of employment, the maximum coverage period for qualified beneficiaries other than the covered employee ends on the later of—

(i) 36 months after the date the covered employee became entitled to Medicare benefits; or

(ii) 18 months (or 29 months, if there is a disability extension) after the date of the covered employee's termination of employment or reduction of hours of employment.

(2) See paragraph (b) of Q&A–3 of this section regarding the determination of when a covered employee becomes entitled to Medicare benefits.

(e) In the case of a qualifying event that is the bankruptcy of the employer, the maximum coverage period for a qualified beneficiary who is the retired covered employee ends on the date of the retired covered employee's death. The maximum coverage period for a qualified beneficiary who is the spouse, surviving spouse, or dependent child of the retired covered employee ends on the earlier of—

(1) The date of the qualified beneficiary's death; or

(2) The date that is 36 months after the death of the retired covered employee.

Q–5: How does a qualified beneficiary become entitled to a disability extension?

A–5: (a) A qualified beneficiary becomes entitled to a disability extension if the requirements of paragraphs (b), (c), and (d) of this Q&A–5 are satisfied with respect to the qualified beneficiary. If the disability extension applies with respect to a qualifying event, it applies with respect to each qualified beneficiary entitled to COBRA continuation coverage because of that qualifying event. Thus, for example, the 29-month maximum coverage period applies to each qualified beneficiary who is not disabled as well as to the qualified beneficiary who is disabled, and it applies independently with respect to each of the qualified beneficiaries. See Q&A–1 in § 54.4980B–8, which permits a plan to require payment of an increased amount during the disability extension.

(b) The requirement of this paragraph (b) is satisfied if a qualifying event occurs that is a termination, or reduction of hours, of a covered employee's employment.

(c) The requirement of this paragraph (c) is satisfied if an individual (whether or not the covered employee) who is a qualified beneficiary in connection with the qualifying event described in paragraph (b) of this Q&A–5 is determined under Title II or XVI of the Social Security Act (42 U.S.C. 401–433 or 1381–1385) to have been disabled at any time during the first 60 days of COBRA continuation coverage. For this purpose, the period of the first 60 days of COBRA continuation coverage is measured from the date of the qualifying event described in paragraph (b) of this Q&A–5 (except that if a loss of coverage would occur at a later date in the absence of an election for COBRA continuation coverage and if the plan provides for the extension of the required periods (as described in paragraph (b) of Q&A–4 of this section) then the period of the first 60 days of COBRA continuation coverage is measured from the date on which the coverage would be lost). However, in the case of a qualified beneficiary who is a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, the period of the first 60 days of COBRA continuation coverage is measured from the date of birth or placement for adoption. For purposes of this paragraph (c), an individual is determined to be disabled within the first 60 days of COBRA continuation coverage if the individual has been determined under Title II or XVI of the Social Security Act to have been disabled before the

first day of COBRA continuation coverage and has not been determined to be no longer disabled at any time between the date of that disability determination and the first day of COBRA continuation coverage.

(d) The requirement of this paragraph (d) is satisfied if any of the qualified beneficiaries affected by the qualifying event described in paragraph (b) of this Q&A–5 provides notice to the plan administrator of the disability determination on a date that is both within 60 days after the date the determination is issued and before the end of the original 18-month maximum coverage period that applies to the qualifying event.

Q–6: Under what circumstances can the maximum coverage period be expanded?

A–6: (a) The maximum coverage period can be expanded if the requirements of Q&A–5 of this section (relating to the disability extension) or paragraph (b) of this Q&A–6 are satisfied.

(b) The requirements of this paragraph (b) are satisfied if a qualifying event that gives rise to an 18-month maximum coverage period (or a 29-month maximum coverage period in the case of a disability extension) is followed, within that 18-month period (or within that 29-month period, in the case of a disability extension), by a second qualifying event (for example, a death or a divorce) that gives rise to a 36-month maximum coverage period. (Thus, a termination of employment following a qualifying event that is a reduction of hours of employment cannot be a second qualifying event that expands the maximum coverage period; the bankruptcy of an employer also cannot be a second qualifying event that expands the maximum coverage period.) In such a case, the original 18-month period (or 29-month period, in the case of a disability extension) is expanded to 36 months, but only for those individuals who were qualified beneficiaries under the group health plan in connection with the first qualifying event and who are still qualified beneficiaries at the time of the second qualifying event. No qualifying event (other than a qualifying event that is the bankruptcy of the employer) can give rise to a maximum coverage period that ends more than 36 months after the date of the first qualifying event (or more than 36 months after the date of the loss of coverage, in the case of a plan that provides for the extension of the required periods; see paragraph (b) in Q&A–4 of this section). For example, if an employee covered by a group health plan that is subject to COBRA terminates employment (for reasons other than gross misconduct) on December 31, 2000, the termination is a qualifying event giving rise to a maximum coverage period that extends for 18 months to June 30, 2002. If the employee dies after the employee and the employee's spouse and dependent children have elected COBRA continuation coverage and on or before June 30, 2002, the spouse and dependent children (except anyone among them whose COBRA continuation coverage had already ended for some other reason) will be able to receive COBRA continuation coverage through December 31, 2003. See Q&A–8(b) of § 54.4980B–2 for a special rule that applies to certain health flexible spending arrangements.

Q–7: If health coverage is provided to a qualified beneficiary after a qualifying event without regard to COBRA continuation coverage (for example, as a result of state or local law, the Uniformed Services Employment and Reemployment Rights Act of 1994 (38 U.S.C. 4315), industry practice, a collective bargaining agreement, severance agreement, or plan procedure), will such alternative coverage extend the maximum coverage period?

A–7: (a) No. The end of the maximum coverage period is measured solely as described in Q&A–4 and Q&A–6 of this section, which is generally from the date of the qualifying event.

(b) If the alternative coverage does not satisfy all the requirements for COBRA continuation coverage, or if the amount that the group health plan requires to be paid for the alternative coverage is greater than the amount required to be paid by similarly situated nonCOBRA beneficiaries for the coverage that the qualified beneficiary can elect to receive as COBRA continuation coverage, the plan covering the qualified beneficiary immediately before the qualifying event must offer the

qualified beneficiary receiving the alternative coverage the opportunity to elect COBRA continuation coverage. See Q&A–1 of § 54.4980B–6.

(c) If an individual rejects COBRA continuation coverage in favor of alternative coverage, then, at the expiration of the alternative coverage period, the individual need not be offered a COBRA election. However, if the individual receiving alternative coverage is a covered employee and the spouse or a dependent child of the individual would lose that alternative coverage as a result of a qualifying event (such as the death of the covered employee), the spouse or dependent child must be given an opportunity to elect to continue that alternative coverage, with a maximum coverage period of 36 months measured from the date of that qualifying event.

Q–8: Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?

A–8: If a qualified beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the maximum coverage period, the group health plan must, during the 180-day period that ends on that expiration date, provide the qualified beneficiary the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated nonCOBRA beneficiaries under the group health plan. If such a conversion option is not otherwise generally available, it need not be made available to qualified beneficiaries.

[T.D. 8812, 64 FR 5184, Feb. 3, 1999, as amended by T.D. 8928, 66 FR 1853, Jan. 10, 2001]

§ 54.4980B–8 Paying for COBRA continuation coverage.

The following questions-and-answers address paying for COBRA continuation coverage:

Q–1: Can a group health plan require payment for COBRA continuation coverage?

A–1: (a) Yes. For any period of COBRA continuation coverage, a group health plan can require the payment of an amount that does not exceed 102 percent of the applicable premium for that period. (See paragraph (b) of this Q&A–1 for a rule permitting a plan to require payment of an increased amount due to the disability extension.) The applicable premium is defined in section 4980B(f)(4). A group health plan can terminate a qualified beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made to the plan with respect to that qualified beneficiary (see Q&A–1 of § 54.4980B–7). For the meaning of *timely payment*, see Q&A–5 of this section.

(b) A group health plan is permitted to require the payment of an amount that does not exceed 150 percent of the applicable premium for any period of COBRA continuation coverage covering a disabled qualified beneficiary (for example, whether single or family coverage) if the coverage would not be required to be made available in the absence of a disability extension. (See Q&A–5 of § 54.4980B–7 for rules to determine whether a qualified beneficiary is entitled to a disability extension.) A plan is not permitted to require the payment of an amount that exceeds 102 percent of the applicable premium for any period of COBRA continuation coverage to which a qualified beneficiary is entitled without regard to the disability extension. Thus, if a qualified beneficiary entitled to a disability extension experiences a second qualifying event within the original 18-month maximum coverage period, then the plan is not permitted to require the payment of an amount that exceeds 102 percent of the applicable premium for any period of COBRA continuation coverage. By contrast, if a qualified beneficiary entitled to a disability extension experiences a second qualifying event after the end of the original 18-month maximum coverage period, then the plan may require the payment of an amount that is up to 150 percent of the applicable premium for the remainder of the period of COBRA continuation coverage (that is, from the beginning of the 19th month through the end of the 36th month) as long as the disabled qualified beneficiary is included in that coverage. The rules of this paragraph (b) are illustrated by the following examples; in each example the group health plan is subject to COBRA:

Example 1. (i) An employer maintains a group health plan. The plan determines the cost of covering individuals under the plan by reference to two categories, individual coverage and family coverage, and the applicable premium is determined for those two categories. An employee and members of the employee's family are covered under the plan. The employee experiences a qualifying event that is the termination of the employee's employment. The employee's family qualifies for the disability extension because of the disability of the employee's spouse. (Timely notice of the disability is provided to the plan administrator.) Timely payment of the amount required by the plan for COBRA continuation coverage for the family (which does not exceed 102 percent of the cost of family coverage under the plan) was made to the plan with respect to the employee's family for the first 18 months of COBRA continuation coverage, and the disabled spouse and the rest of the family continue to receive COBRA continuation coverage through the 29th month.

(ii) Under these facts, the plan may require payment of up to 150 percent of the applicable premium for family coverage in order for the family to receive COBRA continuation coverage from the 19th month through the 29th month. If the plan determined the cost of coverage by reference to three categories (such as employee, employee-plus-one-dependent, employee-plus-two-or-more-dependents) or more than three categories, instead of two categories, the plan could still require, from the 19th month through the 29th month of COBRA continuation coverage, the payment of 150 percent of the cost of coverage for the category of coverage that included the disabled spouse.

Example 2. (i) The facts are the same as in *Example 1*, except that only the covered employee elects and pays for the first 18 months of COBRA continuation coverage.

(ii) Even though the employee's disabled spouse does not elect or pay for COBRA continuation coverage, the employee satisfies the requirements for the disability extension to apply with respect to the employee's qualifying event. Under these facts, the plan may not require the payment of more than 102 percent of the applicable premium for individual coverage for the entire period of the employee's COBRA continuation coverage, including the period from the 19th month through the 29th month. If COBRA continuation coverage had been elected and paid for with respect to other nondisabled members of the employee's family, then the plan could not require the payment of more than 102 percent of the applicable premium for family coverage (or for any other appropriate category of coverage that might apply to that group of qualified beneficiaries under the plan, such as employee-plus-one-dependent or employee-plus-two-or-more-dependents) for those family members to continue their coverage from the 19th month through the 29th month.

(c) A group health plan does not fail to comply with section 9802(b) (which generally prohibits an individual from being charged, on the basis of health status, a higher premium than that charged for similarly situated individuals enrolled in the plan) with respect to a qualified beneficiary entitled to the disability extension merely because the plan requires payment of an amount permitted under paragraph (b) of this Q&A–1.

Q–2: When is the applicable premium determined and when can a group health plan increase the amount it requires to be paid for COBRA continuation coverage?

A–2: (a) The applicable premium for each determination period must be computed and fixed by a group health plan before the determination period begins. A determination period is any 12-month period selected by the plan, but it must be applied consistently from year to year. The determination period is a single period for any benefit package. Thus, each qualified beneficiary does not have a separate determination period beginning on the date (or anniversaries of the date) that COBRA continuation coverage begins for that qualified beneficiary.

(b) During a determination period, a plan can increase the amount it requires to be paid for a qualified beneficiary's COBRA continuation coverage only in the following three cases:

(1) The plan has previously charged less than the maximum amount permitted under Q&A–1 of this section and the increased amount required to be paid does not exceed the maximum amount permitted under Q&A–1 of this section;

(2) The increase occurs during the disability extension and the increased amount required to be paid does not exceed the maximum amount permitted under paragraph (b) of Q&A–1 of this section; or

(3) A qualified beneficiary changes the coverage being received (see paragraph (c) of this Q&A–2 for rules on how the amount the plan requires to be

paid may or must change when a qualified beneficiary changes the coverage being received).

(c) If a plan allows similarly situated active employees who have not experienced a qualifying event to change the coverage they are receiving, then the plan must also allow each qualified beneficiary to change the coverage being received on the same terms as the similarly situated active employees. (See Q&A–4 in §54.4980B–5.) If a qualified beneficiary changes coverage from one benefit package (or a group of benefit packages) to another benefit package (or another group of benefit packages), or adds or eliminates coverage for family members, then the following rules apply. If the change in coverage is to a benefit package, group of benefit packages, or coverage unit (such as family coverage, self-plus-one-dependent, or self-plus-two-or-more-dependents) for which the applicable premium is higher, then the plan may increase the amount that it requires to be paid for COBRA continuation coverage to an amount that does not exceed the amount permitted under Q&A–1 of this section as applied to the new coverage. If the change in coverage is to a benefit package, group of benefit packages, or coverage unit (such as individual or self-plus-one-dependent) for which the applicable premium is lower, then the plan cannot require the payment of an amount that exceeds the amount permitted under Q&A–1 of this section as applied to the new coverage.

Q–3: Must a plan allow payment for COBRA continuation coverage to be made in monthly installments?

A–3: Yes. A group health plan must allow payment for COBRA continuation coverage to be made in monthly installments. A group health plan is permitted to also allow the alternative of payment for COBRA continuation coverage being made at other intervals (for example, weekly, quarterly, or semiannually).

Q–4: Is a plan required to allow a qualified beneficiary to choose to have the first payment for COBRA continuation coverage applied prospectively only?

A–4: No. A plan is permitted to apply the first payment for COBRA continuation coverage to the period of coverage beginning immediately after the date on which coverage under the plan would have been lost on account of the qualifying event. Of course, if the group health plan allows a qualified beneficiary to waive COBRA continuation coverage for any period before electing to receive COBRA continuation coverage, the first payment is not applied to the period of the waiver.

Q–5: What is timely payment for COBRA continuation coverage?

A–5: (a) Except as provided in this paragraph (a) or in paragraph (b) or (d) of this Q&A–5, timely payment for a period of COBRA continuation coverage under a group health plan means payment that is made to the plan by the date that is 30 days after the first day of that period. Payment that is made to the plan by a later date is also considered timely payment if either—

(1) Under the terms of the plan, covered employees or qualified beneficiaries are allowed until that later date to pay for their coverage for the period; or

(2) Under the terms of an arrangement between the employer or employee organization and an insurance company, health maintenance organization, or other entity that provides plan benefits on the employer's or employee organization's behalf, the employer or employee organization is allowed until that later date to pay for coverage of similarly situated nonCOBRA beneficiaries for the period.

(b) Notwithstanding paragraph (a) of this Q&A–5, a plan cannot require payment for any period of COBRA continuation coverage for a qualified beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that qualified beneficiary.

(c) If, after COBRA continuation coverage has been elected for a qualified beneficiary, a provider of health care (such as a physician, hospital, or pharmacy) contacts the plan to confirm coverage of a qualified beneficiary for a period for which the plan has not yet received payment, the plan must give a complete response to the health care provider about the qualified beneficiary's COBRA continuation coverage rights, if any, described in paragraphs

(a), (b), and (d) of this Q&A–5. For example, if the plan provides coverage during the 30- and 45-day grace periods described in paragraphs (a) and (b) of this Q&A–5 but cancels coverage retroactively if payment is not made by the end of the applicable grace period, then the plan must inform a provider with respect to a qualified beneficiary for whom payment has not been received that the qualified beneficiary is covered but that the coverage is subject to retroactive termination if timely payment is not made. Similarly, if the plan cancels coverage if it has not received payment by the first day of a period of coverage but retroactively reinstates coverage if payment is made by the end of the grace period for that period of coverage, then the plan must inform the provider that the qualified beneficiary currently does not have coverage but will have coverage retroactively to the first date of the period if timely payment is made. (See paragraph (b) of Q&A–3 in § 54.4980B–6 for similar rules that the plan must follow in confirming coverage during the election period.)

(d) If timely payment is made to the plan in an amount that is not significantly less than the amount the plan requires to be paid for a period of coverage, then the amount paid is deemed to satisfy the plan's requirement for the amount that must be paid, unless the plan notifies the qualified beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. For this purpose, as a safe harbor, 30 days after the date the notice is provided is deemed to be a reasonable period of time. An amount is not significantly less than the amount the plan requires to be paid for a period of coverage if and only if the shortfall is no greater than the lesser of the following two amounts:

(1) Fifty dollars (or such other amount as the Commissioner may provide in a revenue ruling, notice, or other guidance published in the Internal Revenue Bulletin (see § 601.601(d)(2)(ii) of this chapter)); or

(2) 10 percent of the amount the plan requires to be paid.

(e) Payment is considered made on the date on which it is sent to the plan.

[T.D. 8812, 64 FR 5186, Feb. 3, 1999, as amended by T.D. 8928, 66 FR 1854, Jan. 10, 2001]

§ 54.4980B–9 Business reorganizations and employer withdrawals from multiemployer plans.

The following questions-and-answers address who has the obligation to make COBRA continuation coverage available to affected qualified beneficiaries in the context of business reorganizations and employer withdrawals from multiemployer plans:

Q–1: For purposes of this section, what are a business reorganization, a stock sale, and an asset sale?

A–1: For purposes of this section:

(a) A *business reorganization* is a stock sale or an asset sale.

(b) A *stock sale* is a transfer of stock in a corporation that causes the corporation to become a different employer or a member of a different employer. (See Q&A–2 of § 54.4980B–2, which defines *employer* to include all members of a controlled group of corporations.) Thus, for example, a sale or distribution of stock in a corporation that causes the corporation to cease to be a member of one controlled group of corporations, whether or not it becomes a member of another controlled group of corporations, is a stock sale.

(c) An *asset sale* is a transfer of substantial assets, such as a plant or division or substantially all the assets of a trade or business.

(d) The rules of § 1.414(b)–1 of this chapter apply in determining what constitutes a controlled group of corporations, and the rules of §§ 1.414(c)–1 through 1.414(c)–5 of this chapter apply in determining what constitutes a group of trades or businesses under common control.

Q–2: In the case of a stock sale, what are the selling group, the acquired organization, and the buying group?

A–2: In the case of a stock sale—

(a) The *selling group* is the controlled group of corporations, or the group of trades or businesses under common control, of which a corporation ceases to be a member as a result of the stock sale;

(b) The *acquired organization* is the corporation that ceases to be a member

of the selling group as a result of the stock sale; and

(c) The *buying group* is the controlled group of corporations, or the group of trades or businesses under common control, of which the acquired organization becomes a member as a result of the stock sale. If the acquired organization does not become a member of such a group, the *buying group* is the acquired organization.

Q–3: In the case of an asset sale, what are the selling group and the buying group?

A–3: In the case of an asset sale—

(a) The *selling group* is the controlled group of corporations or the group of trades or businesses under common control that includes the corporation or other trade or business that is selling the assets; and

(b) The *buying group* is the controlled group of corporations or the group of trades or businesses under common control that includes the corporation or other trade or business that is buying the assets.

Q–4: Who is an M&A qualified beneficiary?

A–4: (a) Asset sales: In the case of an asset sale, an individual is an M&A qualified beneficiary if the individual is a qualified beneficiary whose qualifying event occurred prior to or in connection with the sale and who is, or whose qualifying event occurred in connection with, a covered employee whose last employment prior to the qualifying event was associated with the assets being sold.

(b) Stock sales: In the case of a stock sale, an individual is an M&A qualified beneficiary if the individual is a qualified beneficiary whose qualifying event occurred prior to or in connection with the sale and who is, or whose qualifying event occurred in connection with, a covered employee whose last employment prior to the qualifying event was with the acquired organization.

(c) In the case of a qualified beneficiary who has experienced more than one qualifying event with respect to her or his current right to COBRA continuation coverage, the qualifying event referred to in paragraphs (a) and (b) of this Q&A–4 is the first qualifying event.

Q–5: In the case of a stock sale, is the sale a qualifying event with respect to a covered employee who is employed by the acquired organization before the sale and who continues to be employed by the acquired organization after the sale, or with respect to the spouse or dependent children of such a covered employee?

A–5: No. A covered employee who continues to be employed by the acquired organization after the sale does not experience a termination of employment as a result of the sale. Accordingly, the sale is not a qualifying event with respect to the covered employee, or with respect to the covered employee's spouse or dependent children, regardless of whether they are provided with group health coverage after the sale, and neither the covered employee, nor the covered employee's spouse or dependent children, become qualified beneficiaries as a result of the sale.

Q–6: In the case of an asset sale, is the sale a qualifying event with respect to a covered employee whose employment immediately before the sale was associated with the purchased assets, or with respect to the spouse or dependent children of such a covered employee who are covered under a group health plan of the selling group immediately before the sale?

A–6: (a) Yes, unless—

(1) The buying group is a successor employer under paragraph (c) of Q&A–8 of this section or Q&A–2 of § 54.4980B–2, and the covered employee is employed by the buying group immediately after the sale; or

(2) The covered employee (or the spouse or any dependent child of the covered employee) does not lose coverage (within the meaning of paragraph (c) in Q&A–1 of § 54.4980B-4) under a group health plan of the selling group after the sale.

(b) Unless the conditions in paragraph (a)(1) or (2) of this Q&A–6 are satisfied, such a covered employee experiences a termination of employment with the selling group as a result of the asset sale, regardless of whether the covered employee is employed by the buying group or whether the covered employee's employment is associated with the purchased assets after the

sale. Accordingly, the covered employee, and the spouse and dependent children of the covered employee who lose coverage under a plan of the selling group in connection with the sale, are M&A qualified beneficiaries in connection with the sale.

Q–7: In a business reorganization, are the buying group and the selling group permitted to allocate by contract the responsibility to make COBRA continuation coverage available to M&A qualified beneficiaries?

A–7: Yes. Nothing in this section prohibits a selling group and a buying group from allocating to one or the other of the parties in a purchase agreement the responsibility to provide the coverage required under §§ 54.4980B–1 through 54.4980B–10. However, if and to the extent that the party assigned this responsibility under the terms of the contract fails to perform, the party who has the obligation under Q&A–8 of this section to make COBRA continuation coverage available to M&A qualified beneficiaries continues to have that obligation.

Q–8: Which group health plan has the obligation to make COBRA continuation coverage available to M&A qualified beneficiaries in a business reorganization?

A–8: (a) In the case of a business reorganization (whether a stock sale or an asset sale), so long as the selling group maintains a group health plan after the sale, a group health plan maintained by the selling group has the obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to that sale. This Q&A–8 prescribes rules for cases in which the selling group ceases to provide any group health plan to any employee in connection with the sale. Paragraph (b) of this Q&A–8 contains these rules for stock sales, and paragraph (c) of this Q&A–8 contains these rules for asset sales. Neither a stock sale nor an asset sale has any effect on the COBRA continuation coverage requirements applicable to any group health plan for any period before the sale.

(b)(1) In the case of a stock sale, if the selling group ceases to provide any group health plan to any employee in connection with the sale, a group health plan maintained by the buying group has the obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to that stock sale. A group health plan of the buying group has this obligation beginning on the later of the following two dates and continuing as long as the buying group continues to maintain a group health plan (but subject to the rules in § 54.4980B–7, relating to the duration of COBRA continuation coverage)—

(i) The date the selling group ceases to provide any group health plan to any employee; or

(ii) The date of the stock sale.

(2) The determination of whether the selling group's cessation of providing any group health plan to any employee is in connection with the stock sale is based on all of the relevant facts and circumstances. A group health plan of the buying group does not, as a result of the stock sale, have an obligation to make COBRA continuation coverage available to those qualified beneficiaries of the selling group who are not M&A qualified beneficiaries with respect to that sale.

(c)(1) In the case of an asset sale, if the selling group ceases to provide any group health plan to any employee in connection with the sale and if the buying group continues the business operations associated with the assets purchased from the selling group without interruption or substantial change, then the buying group is a successor employer to the selling group in connection with that asset sale. A buying group does not fail to be a successor employer in connection with an asset sale merely because the asset sale takes place in connection with a proceeding in bankruptcy under Title 11 of the United States Code. If the buying group is a successor employer, a group health plan maintained by the buying group has the obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to that asset sale. A group health plan of the buying group has this obligation beginning on the later of the following two dates and continuing as long as the buying group continues to maintain a group health

plan (but subject to the rules in § 54.4980B–7, relating to the duration of COBRA continuation coverage)—

(i) The date the selling group ceases to provide any group health plan to any employee; or

(ii) The date of the asset sale.

(2) The determination of whether the selling group's cessation of providing any group health plan to any employee is in connection with the asset sale is based on all of the relevant facts and circumstances. A group health plan of the buying group does not, as a result of the asset sale, have an obligation to make COBRA continuation coverage available to those qualified beneficiaries of the selling group who are not M&A qualified beneficiaries with respect to that sale.

(d) The rules of Q&A–1 through Q&A–7 of this section and this Q&A–8 are illustrated by the following examples; in each example, each group health plan is subject to COBRA:

Stock Sale Examples

Example 1. (i) Selling Group *S* consists of three corporations, *A*, *B*, and *C*. Buying Group *P* consists of two corporations, *D* and *E*. *P* enters into a contract to purchase all the stock of *C* from *S* effective July 1, 2002. Before the sale of *C*, *S* maintains a single group health plan for the employees of *A*, *B*, and *C* (and their families). *P* maintains a single group health plan for the employees of *D* and *E* (and their families). Effective July 1, 2002, the employees of *C* (and their families) become covered under *P*'s plan. On June 30, 2002, there are 48 qualified beneficiaries receiving COBRA continuation coverage under *S*'s plan, 15 of whom are M&A qualified beneficiaries with respect to the sale of *C*. (The other 33 qualified beneficiaries had qualifying events in connection with a covered employee whose last employment before the qualifying event was with either *A* or *B*.)

(ii) Under these facts, *S*'s plan continues to have the obligation to make COBRA continuation coverage available to the 15 M&A qualified beneficiaries under *S*'s plan after the sale of *C* to *P*. The employees who continue in employment with *C* do not experience a qualifying event by virtue of *P*'s acquisition of *C*. If they experience a qualifying event after the sale, then the group health plan of *P* has the obligation to make COBRA continuation coverage available to them.

Example 2. (i) Selling Group *S* consists of three corporations, *A*, *B*, and *C*. Each of *A*, *B*, and *C* maintains a group health plan for its employees (and their families). Buying Group *P* consists of two corporations, *D* and *E*. *P* enters into a contract to purchase all of the stock of *C* from *S* effective July 1, 2002. As of June 30, 2002, there are 14 qualified beneficiaries receiving COBRA continuation coverage under *C*'s plan. *C* continues to employ all of its employees and continues to maintain its group health plan after being acquired by *P* on July 1, 2002.

(ii) Under these facts, *C* is an acquired organization and the 14 qualified beneficiaries under *C*'s plan are M&A qualified beneficiaries. A group health plan of *S* (that is, either the plan maintained by *A* or the plan maintained by *B*) has the obligation to make COBRA continuation coverage available to the 14 M&A qualified beneficiaries. *S* and *P* could negotiate to have *C*'s plan continue to make COBRA continuation coverage available to the 14 M&A qualified beneficiaries. In such a case, neither *A*'s plan nor *B*'s plan would make COBRA continuation coverage available to the 14 M&A qualified beneficiaries unless *C*'s plan failed to fulfill its contractual responsibility to make COBRA continuation coverage available to the M&A qualified beneficiaries. *C*'s employees (and their spouses and dependent children) do not experience a qualifying event in connection with *P*'s acquisition of *C*, and consequently no plan maintained by either *P* or *S* has any obligation to make COBRA continuation coverage available to *C*'s employees (or their spouses or dependent children) in connection with the transfer of stock in *C* from *S* to *P*.

Example 3. (i) The facts are the same as in *Example 2*, except that *C* ceases to employ two employees on June 30, 2002, and those two employees never become covered under *P*'s plan.

(ii) Under these facts, the two employees experience a qualifying event on June 30, 2002 because their termination of employment causes a loss of group health coverage. A group health plan of *S* (that is, either the plan maintained by *A* or the plan maintained by *B*) has the obligation to make COBRA continuation coverage available to the two employees (and to any spouse or dependent child of the two employees who loses coverage under *C*'s plan in connection with the termination of employment of the two employees) because they are M&A qualified beneficiaries with respect to the sale of *C*.

Example 4. (i) Selling Group *S* consists of three corporations, *A*, *B*, and *C*. Buying Group *P* consists of two corporations, *D* and *E*. *P* enters into a contract to purchase all of the stock of *C* from *S* effective July 1, 2002. Before the sale of *C*, *S* maintains a single group health plan for the employees of *A*, *B*, and *C* (and their families). *P* maintains a single group health plan for the employees of *D* and *E* (and their families). Effective July 1, 2002, the employees of *C* (and their families) become covered under *P*'s plan. On June 30,

2002, there are 25 qualified beneficiaries receiving COBRA continuation coverage under *S*'s plan, 20 of whom are M&A qualified beneficiaries with respect to the sale of *C*. (The other five qualified beneficiaries had qualifying events in connection with a covered employee whose last employment before the qualifying event was with either *A* or *B*.) S terminates its group health plan effective June 30, 2002 and begins to liquidate the assets of *A* and *B* and to lay off the employees of *A* and *B*.

(ii) Under these facts, *S* ceases to provide a group health plan to any employee in connection with the sale of *C* to *P*. Thus, beginning July 1, 2002 *P*'s plan has the obligation to make COBRA continuation coverage available to the 20 M&A qualified beneficiaries, but *P* is not obligated to make COBRA continuation coverage available to the other 5 qualified beneficiaries with respect to *S*'s plan as of June 30, 2002 or to any of the employees of *A* or *B* whose employment is terminated by *S* (or to any of those employees' spouses or dependent children).

Asset Sale Examples

Example 5. (i) Selling Group *S* provides group health plan coverage to employees at each of its operating divisions. *S* sells the assets of one of its divisions to Buying Group *P*. Under the terms of the group health plan covering the employees at the division being sold, their coverage will end on the date of the sale. *P* hires all but one of those employees, gives them the same positions that they had with *S* before the sale, and provides them with coverage under a group health plan. Immediately before the sale, there are two qualified beneficiaries receiving COBRA continuation coverage under a group health plan of *S* whose qualifying events occurred in connection with a covered employee whose last employment prior to the qualifying event was associated with the assets sold to *P*.

(ii) These two qualified beneficiaries are M&A qualified beneficiaries with respect to the asset sale to *P*. Under these facts, a group health plan of *S* retains the obligation to make COBRA continuation coverage available to these two M&A qualified beneficiaries. In addition, the one employee *P* does not hire as well as all of the employees *P* hires (and the spouses and dependent children of these employees) who were covered under a group health plan of *S* on the day before the sale are M&A qualified beneficiaries with respect to the sale. A group health plan of *S* also has the obligation to make COBRA continuation coverage available to these M&A qualified beneficiaries.

Example 6. (i) Selling Group *S* provides group health plan coverage to employees at each of its operating divisions. *S* sells substantially all of the assets of all of its divisions to Buying Group *P*, and *S* ceases to provide any group health plan to any employee on the date of the sale. *P* hires all but one of *S*'s employees on the date of the asset sale by *S*, gives those employees the same positions that they had with *S* before the sale, and continues the business operations of those divisions without substantial change or interruption. *P* provides these employees with coverage under a group health plan. Immediately before the sale, there are 10 qualified beneficiaries receiving COBRA continuation coverage under a group health plan of *S* whose qualifying events occurred in connection with a covered employee whose last employment prior to the qualifying event was associated with the assets sold to *P*.

(ii) These 10 qualified beneficiaries are M&A qualified beneficiaries with respect to the asset sale to *P*. Under these facts, *P* is a successor employer described in paragraph (c) of this Q&A–8. Thus, a group health plan of *P* has the obligation to make COBRA continuation coverage available to these 10 M&A qualified beneficiaries.

(iii) The one employee that *P* does not hire and the family members of that employee are also M&A qualified beneficiaries with respect to the sale. A group health plan of *P* also has the obligation to make COBRA continuation coverage available to these M&A qualified beneficiaries.

(iv) The employees who continue in employment in connection with the asset sale (and their family members) and who were covered under a group health plan of *S* on the day before the sale are not M&A qualified beneficiaries because *P* is a successor employer to *S* in connection with the asset sale. Thus, no group health plan of *P* has any obligation to make COBRA continuation coverage available to these continuing employees with respect to the qualifying event that resulted from their losing coverage under *S*'s plan in connection with the asset sale.

Example 7. (i) Selling Group *S* provides group health plan coverage to employees at each of its two operating divisions. *S* sells the assets of one of its divisions to Buying Group *P1*. Under the terms of the group health plan covering the employees at the division being sold, their coverage will end on the date of the sale. *P1* hires all but one of those employees, gives them the same positions that they had with *S* before the sale, and provides them with coverage under a group health plan.

(ii) Under these facts, a group health plan of *S* has the obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to the sale to *P1*. (If an M&A qualified beneficiary first became covered under *P1*'s plan after electing COBRA continuation coverage under *S*'s plan, then *S*'s plan could terminate the COBRA continuation coverage once the M&A qualified beneficiary became covered under

P1's plan, provided that the remaining conditions of Q&A–2 of § 54.4980B–7 were satisfied.)

(iii) Several months after the sale to *P1*, *S* sells the assets of its remaining division to Buying Group *P2*, and *S* ceases to provide any group health plan to any employee on the date of that sale. Thus, under Q&A–1 of § 54.4980B–7, *S* ceases to have an obligation to make COBRA continuation coverage available to any qualified beneficiary on the date of the sale to *P2*. *P1* and *P2* are unrelated organizations.

(iv) Even if it was foreseeable that *S* would sell its remaining division to an unrelated third party after the sale to *P1*, under these facts the cessation of *S* to provide any group health plan to any employee on the date of the sale to *P2* is not in connection with the asset sale to *P1*. Thus, even after the date *S* ceases to provide any group health plan to any employee, no group health plan of *P1* has any obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to the asset sale to *P1* by *S*. If *P2* is a successor employer under the rules of paragraph (c) of this Q&A–8 and maintains one or more group health plans after the sale, then a group health plan of *P2* would have an obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to the asset sale to *P2* by *S* (but in such a case employees of *S* before the sale who continued working for *P2* after the sale would not be M&A qualified beneficiaries). However, even in such a case, no group health plan of *P2* would have an obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to the asset sale to *P1* by *S*. Thus, under these facts, after *S* has ceased to provide any group health plan to any employee, no plan has an obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to the asset sale to *P1*.

Example 8. (i) Selling Group *S* provides group health plan coverage to employees at each of its operating divisions. *S* sells substantially all of the assets of all of its divisions to Buying Group *P*. *P* hires most of *S*'s employees on the date of the purchase of *S*'s assets, retains those employees in the same positions that they had with *S* before the purchase, and continues the business operations of those divisions without substantial change or interruption. *P* provides these employees with coverage under a group health plan. *S* continues to employ a few employees for the principal purpose of winding up the affairs of *S* in preparation for liquidation. *S* continues to provide coverage under a group health plan to these few remaining employees for several weeks after the date of the sale and then ceases to provide any group health plan to any employee.

(ii) Under these facts, the cessation by *S* to provide any group health plan to any employee is in connection with the asset sale to *P*. Because of this, and because *P* continued the business operations associated with those assets without substantial change or interruption, *P* is a successor employer to *S* with respect to the asset sale. Thus, a group health plan of *P* has the obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to the sale beginning on the date that *S* ceases to provide any group health plan to any employee. (A group health plan of *S* retains this obligation for the several weeks after the date of the sale until *S* ceases to provide any group health plan to any employee.)

Q–9: Can the cessation of contributions by an employer to a multiemployer group health plan be a qualifying event?

A–9: The cessation of contributions by an employer to a multiemployer group health plan is not itself a qualifying event, even though the cessation of contributions may cause current employees (and their spouses and dependent children) to lose coverage under the multiemployer plan. An event coinciding with the employer's cessation of contributions (such as a reduction of hours of employment in the case of striking employees) will constitute a qualifying event if it otherwise satisfies the requirements of Q&A–1 of § 54.4980B–4.

Q–10: If an employer stops contributing to a multiemployer group health plan, does the multiemployer plan have the obligation to make COBRA continuation coverage available to a qualified beneficiary who was receiving coverage under the multiemployer plan on the day before the cessation of contributions and who is, or whose qualifying event occurred in connection with, a covered employee whose last employment prior to the qualifying event was with the employer that has stopped contributing to the multiemployer plan?

A–10: (a) In general, yes. (See Q&A–3 of § 54.4980B–2 for a definition of *multiemployer plan*.) If, however, the employer that stops contributing to the multiemployer plan makes group health plan coverage available to (or starts contributing to another multiemployer plan that is a group health plan with respect to) a class of the employer's employees formerly covered under the multiemployer plan, the plan maintained by the employer (or the

other multiemployer plan), from that date forward, has the obligation to make COBRA continuation coverage available to any qualified beneficiary who was receiving coverage under the multiemployer plan on the day before the cessation of contributions and who is, or whose qualifying event occurred in connection with, a covered employee whose last employment prior to the qualifying event was with the employer.

(b) The rules of Q&A–9 of this section and this Q&A–10 are illustrated by the following examples; in each example, each group health plan is subject to COBRA:

Example 1. (i) Employer *Z* employs a class of employees covered by a collective bargaining agreement and participating in multiemployer group health plan *M*. As required by the collective bargaining agreement, *Z* has been making contributions to *M*. *Z* experiences financial difficulties and stops making contributions to *M* but continues to employ all of the employees covered by the collective bargaining agreement. *Z*'s cessation of contributions to *M* causes those employees (and their spouses and dependent children) to lose coverage under *M*. *Z* does not make group health plan coverage available to any of the employees covered by the collective bargaining agreement.

(ii) After *Z* stops contributing to *M*, *M* continues to have the obligation to make COBRA continuation coverage available to any qualified beneficiary who experienced a qualifying event that preceded or coincided with the cessation of contributions to *M* and whose coverage under *M* on the day before the qualifying event was due to an employment affiliation with *Z*. The loss of coverage under *M* for those employees of *Z* who continue in employment (and the loss of coverage for their spouses and dependent children) does not constitute a qualifying event.

Example 2. (i) The facts are the same as in *Example 1* except that *B*, one of the employees covered under *M* before *Z* stops contributing to *M*, is transferred into management. *Z* maintains a group health plan for managers and *B* becomes eligible for coverage under the plan on the day of *B*'s transfer.

(ii) Under these facts, *Z* does not make group health plan coverage available to a class of employees formerly covered under *M* after *B* becomes eligible under *Z*'s group health plan for managers. Accordingly, *M* continues to have the obligation to make COBRA continuation coverage available to any qualified beneficiary who experienced a qualifying event that preceded or coincided with the cessation of contributions to *M* and whose coverage under *M* on the day before the qualifying event was due to an employment affiliation with *Z*.

Example 3. (i) Employer *Y* employs two classes of employees—skilled and unskilled laborers—covered by a collective bargaining agreement and participating in multiemployer group health plan *M*. As required by the collective bargaining agreement, *Y* has been making contributions to *M*. *Y* stops making contributions to *M* but continues to employ all the employees covered by the collective bargaining agreement. *Y*'s cessation of contributions to *M* causes those employees (and their spouses and dependent children) to lose coverage under *M*. *Y* makes group health plan coverage available to the skilled laborers immediately after their coverage ceases under *M*, but *Y* does not make group health plan coverage available to any of the unskilled laborers.

(ii) Under these facts, because *Y* makes group health plan coverage available to a class of employees previously covered under *M* immediately after both classes of employees lose coverage under *M*, *Y* alone has the obligation to make COBRA continuation coverage available to any qualified beneficiary who experienced a qualifying event that preceded or coincided with the cessation of contributions to *M* and whose coverage under *M* on the day before the qualifying event was due to an employment affiliation with *Y*, regardless of whether the employment affiliation was as a skilled or unskilled laborer. However, the loss of coverage under *M* for those employees of *Y* who continue in employment (and the loss of coverage for their spouses and dependent children) does not constitute a qualifying event.

Example 4. (i) Employer *X* employs a class of employees covered by a collective bargaining agreement and participating in multiemployer group health plan *M*. As required by the collective bargaining agreement, *X* has been making contributions to *M*. *X* experiences financial difficulties and is forced into bankruptcy by its creditors. *X* continues to employ all of the employees covered by the collective bargaining agreement. *X* also continues to make contributions to *M* until the current collective bargaining agreement expires, on June 30, 2001, and then *X* stops making contributions to *M*. *X*'s employees (and their spouses and dependent children) lose coverage under *M* effective July 1, 2001. *X* does not enter into another collective bargaining agreement covering the class of employees covered by the expired collective bargaining agreement. Effective September 1, 2001, *X* establishes a group health plan covering the class of employees formerly covered by the collective bargaining agreement. The group health plan also covers their spouses and dependent children.

(ii) Under these facts, *M* has the obligation to make COBRA continuation coverage

available from July 1, 2001 until August 31, 2001, and the group health plan established by *X* has the obligation to make COBRA continuation coverage available from September 1, 2001 until the obligation ends (see Q&A–1 of § 54.4980B–7) to any qualified beneficiary who experienced a qualifying event that preceded or coincided with the cessation of contributions to *M* and whose coverage under *M* on the day before the qualifying event was due to an employment affiliation with *X*. The loss of coverage under *M* for those employees of *X* who continue in employment (and the loss of coverage for their spouses and dependent children) does not constitute a qualifying event.

Example 5. (i) Employer *W* employs a class of employees covered by a collective bargaining agreement and participating in multiemployer group health plan *M*. As required by the collective bargaining agreement, *W* has been making contributions to *M*. The employees covered by the collective bargaining agreement vote to decertify their current employee representative effective January 1, 2002 and vote to certify a new employee representative effective the same date. As a consequence, on January 1, 2002 they cease to be covered under *M* and commence to be covered under multiemployer group health plan *N*.

(ii) Effective January 1, 2002, *N* has the obligation to make COBRA continuation coverage available to any qualified beneficiary who experienced a qualifying event that preceded or coincided with the cessation of contributions to *M* and whose coverage under *M* on the day before the qualifying event was due to an employment affiliation with W. The loss of coverage under *M* for those employees of W who continue in employment (and the loss of coverage for their spouses and dependent children) does not constitute a qualifying event.

[T.D. 8928, 66 FR 1855, Jan. 10, 2001]

§ 54.4980B–10 Interaction of FMLA and COBRA.

The following questions-and-answers address how the taking of leave under the Family and Medical Leave Act of 1993 (FMLA) (29 U.S.C. 2601–2619) affects the COBRA continuation coverage requirements:

Q–1: In what circumstances does a qualifying event occur if an employee does not return from leave taken under FMLA?

A–1: (a) The taking of leave under FMLA does not constitute a qualifying event. A qualifying event under Q&A–1 of § 54.4980B–4 occurs, however, if—

(1) An employee (or the spouse or a dependent child of the employee) is covered on the day before the first day of FMLA leave (or becomes covered during the FMLA leave) under a group health plan of the employee's employer;

(2) The employee does not return to employment with the employer at the end of the FMLA leave; and

(3) The employee (or the spouse or a dependent child of the employee) would, in the absence of COBRA continuation coverage, lose coverage under the group health plan before the end of the maximum coverage period.

(b) However, the satisfaction of the three conditions in paragraph (a) of this Q&A–1 does not constitute a qualifying event if the employer eliminates, on or before the last day of the employee's FMLA leave, coverage under a group health plan for the class of employees (while continuing to employ that class of employees) to which the employee would have belonged if the employee had not taken FMLA leave.

Q–2: If a qualifying event described in Q&A–1 of this section occurs, when does it occur, and how is the maximum coverage period measured?

A–2: A qualifying event described in Q&A–1 of this section occurs on the last day of FMLA leave. (The determination of when FMLA leave ends is not made under the rules of this section. See the FMLA regulations, 29 CFR Part 825 (§§ 825.100–825.800).) The maximum coverage period (see Q&A–4 of § 54.4980B–7) is measured from the date of the qualifying event (that is, the last day of FMLA leave). If, however, coverage under the group health plan is lost at a later date and the plan provides for the extension of the required periods (see paragraph (b) of Q&A–4 of § 54.4980B–7), then the maximum coverage period is measured from the date when coverage is lost. The rules of this Q&A–2 are illustrated by the following examples:

Example 1. (i) Employee *B* is covered under the group health plan of Employer *X* on January 31, 2001. *B* takes FMLA leave beginning February 1, 2001. *B*'s last day of FMLA leave is 12 weeks later, on April 25, 2001, and *B* does not return to work with *X* at the end of the FMLA leave. If *B* does not elect COBRA continuation coverage, *B* will not be covered under the group health plan of *X* as of April 26, 2001.

(ii) *B* experiences a qualifying event on April 25, 2001, and the maximum coverage period is measured from that date. (This is the case even if, for part or all of the FMLA leave, *B* fails to pay the employee portion of premiums for coverage under the group health plan of *X* and is not covered under *X*'s plan. See Q&A–3 of this section.)

Example 2. (i) Employee *C* and *C*'s spouse are covered under the group health plan of Employer *Y* on August 15, 2001. *C* takes FMLA leave beginning August 16, 2001. *C* informs *Y* less than 12 weeks later, on September 28, 2001, that *C* will not be returning to work. Under the FMLA regulations, 29 CFR Part 825 (§§825.100–825.800), *C*'s last day of FMLA leave is September 28, 2001. *C* does not return to work with *Y* at the end of the FMLA leave. If *C* and *C*'s spouse do not elect COBRA continuation coverage, they will not be covered under the group health plan of *Y* as of September 29, 2001.

(ii) *C* and *C*'s spouse experience a qualifying event on September 28, 2001, and the maximum coverage period (generally 18 months) is measured from that date. (This is the case even if, for part or all of the FMLA leave, *C* fails to pay the employee portion of premiums for coverage under the group health plan of *Y* and *C* or *C*'s spouse is not covered under *Y*'s plan. See Q&A–3 of this section.)

Q–3: If an employee fails to pay the employee portion of premiums for coverage under a group health plan during FMLA leave or declines coverage under a group health plan during FMLA leave, does this affect the determination of whether or when the employee has experienced a qualifying event?

A–3: No. Any lapse of coverage under a group health plan during FMLA leave is irrelevant in determining whether a set of circumstances constitutes a qualifying event under Q&A–1 of this section or when such a qualifying event occurs under Q&A–2 of this section.

Q–4: Is the application of the rules in Q&A–1 through Q&A–3 of this section affected by a requirement of state or local law to provide a period of coverage longer than that required under FMLA?

A–4: No. Any state or local law that requires coverage under a group health plan to be maintained during a leave of absence for a period longer than that required under FMLA (for example, for 16 weeks of leave rather than for the 12 weeks required under FMLA) is disregarded for purposes of determining when a qualifying event occurs under Q&A–1 through Q&A–3 of this section.

Q–5: May COBRA continuation coverage be conditioned upon reimbursement of the premiums paid by the employer for coverage under a group health plan during FMLA leave?

A–5: No. The U.S. Department of Labor has published rules describing the circumstances in which an employer may recover premiums it pays to maintain coverage, including family coverage, under a group health plan during FMLA leave from an employee who fails to return from leave. See 29 CFR 825.213. Even if recovery of premiums is permitted under 29 CFR 825.213, the right to COBRA continuation coverage cannot be conditioned upon the employee's reimbursement of the employer for premiums the employer paid to maintain coverage under a group health plan during FMLA leave.

[T.D. 8928, 66 FR 1855, Jan. 10, 2001]

§ 54.4981A–1T Tax on excess distributions and excess accumulations (temporary).

The following questions and answers relate to the tax on excess distributions and excess accumulations under section 4981A of the Internal Revenue Code of 1986, as added by section 1133 of the Tax Reform Act of 1986 (Pub. L. 99–514) (TRA '86).

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a. General Provisions and Excess Distributions

a-1: Q. What changes were made by section 1133 of TRA '86 regarding excise taxes applicable to distributions from qualified employer plans and individual retirement plans?

A. Section 1133 of TRA '86 added section 4981A to the Code. Section 4981A imposes an excise tax of 15 percent on (a) excess distributions, as defined in section 4981A(c)(1) and Q&A a-2 of this section, and (b) excess accumulations, as defined in section 4981A(d)(3) and Q&A d-2 of this section. The excise tax

on excess distributions generally applies to excess distributions made after December 31, 1986 (see Q&A c-6 of this section). The excise tax on excess accumulations applies to estates of decedents dying after December 31, 1986 (see Q&A d-11 of this section). Excess distributions are certain distributions from qualified employer plans and individual retirement plans. Excess accumulations are certain amounts held on the date of death of an employee or individual by qualified plans and individual retirement plans.

a-2: Q. How are excess distributions defined?

A. Excess distributions are generally defined as the excess of the aggregate amount of distributions received by or with respect to an individual during a calendar year over the greater of (a) $150,000 (unindexed) or (b) $112,500 (indexed as provided in Q&A a-9 of this section beginning in 1988 for cost-of-living increases). Certain individuals may elect to have the portion of their excess distributions that is subject to tax determined under a ''special grandfather'' rule that is described below (see Q&A b-1 through b-14 of this section).

a-3: Q. Distributions from what plans and arrangements are taken into account in applying section 4981A?

A. (a) *General rule.* Section 4981A applies to distributions under any qualified employer plan or individual retirement plan described in section 4981A(e). For this purpose, a qualified employer plan means any—

(1) Qualified pension, profit-sharing or stock bonus plan described in section 401(a) that includes a trust exempt from tax under section 501(a);

(2) Annuity plan described in section 403(a);

(3) Annuity contract, custodial account, or retirement income account described in section 403(b)(1), 403(b)(7) or 403(b)(9); and

(4) Qualified bond purchase plan described in section 405(a) prior to that section's repeal by section 491(a) of the Tax Reform Act of 1984 (TRA '84).

(b) *Individual retirement plan.* An individual retirement plan is defined in section 7701(a)(37) and means any individual retirement account described in section 408(a) or individual retirement annuity described in section 408(b). Also, an individual retirement plan includes a retirement bond described in section 409(a) prior to that section's repeal by section 491(b) of the Tax Reform Act of 1984 (TRA '84).

(c) *Other distributions.* (1) Distributions under any plan, contract or account that has at any time been treated as a qualified employer plan or individual retirement plan described in paragraph (a) or (b) of this Q&A a–3 will be treated for purposes of section 4981A as distributions from a qualified employer plan or individual retirement plan whether or not such plan, contract, or account satisfies the applicable qualification requirements at the time of the distribution.

(2)(i) For purposes of this paragraph (c), an employer plan will be considered to have been treated as a qualified employer plan if any employer maintaining the plan has at any time filed an income tax return and claimed deductions that would be allowable under section 404 (and that were not disallowed) only if the plan was a qualified employer plan under section 401(a) or 403(a). Similarly, if an income tax return has been filed at any time with respect to the trust (or plan or insurance company), and the income of the trust (insurance company, etc.) is reported (and is not disallowed) based on the trust (or plan) being treated as a qualified employer plan described in section 401(a), or 403 (a) or (b), then the employer plan is considered to have been treated as a qualified employer plan.

(ii) For purposes of this paragraph (c), an individual retirement plan (IRA) will be considered to have been treated as a qualified IRA if any contributions to the IRA were either deducted (or designated as a nondeductible contribution described in section 408(o)) on a filed individual income tax return or excluded from an individual's gross income on a filed income tax return because such contributions were reported as regular contributions or rollover contributions (such as those described in section 402(a)(5), 403(a)(4), 403(b)(8) or 408(d)(3)) to an IRA described in section 408 (a) or (b) (or section 409 of pre-1984 law). Similar treatment applies to an employer contribution to a simplified

employee pension described in section 408(k), if such contribution is deducted on an employer's filed income tax return, including a self-employed individual's return.

a–4: Q. Which distributions with respect to an individual under a qualified employer plan or an individual retirement plan are excluded from consideration for purposes of determining an individual's excess distributions?

A. (a) *Exclusions.* In determining the extent to which an individual has excess distributions for a calendar year, the following distributions are disregarded—

(1) Any distribution received by any person with respect to an individual as a result of the death of that individual.

(2) Any distribution with respect to an individual that is received by an alternate payee under a qualified domestic relations order within the meaning of section 414(p) that is includible in the income of the alternate payee.

(3) Any distribution with respect to an individual that is attributable to the individual's investment in the contract as determined under the rules of section 72(f). This would include, for example, distributions that are excluded from gross income under section 72 because they are treated as a recovery of after-tax employee contributions from a qualified employer plan or nondeductible contributions from an individual retirement plan.

(4) Any portion of a distribution to the extent that it is not included in gross income by reason of a rollover contribution described in section 402(a)(5), 403(a)(4), 403(b)(8), or 408(d)(3).

(5) Any health coverage or any distribution of medical benefits provided under an arrangement described in section 401(h) to the extent that the coverage or distribution is excludible under section 104, 105, or 106.

(b) *Alternate payee.* Any distributions to an alternate payee described in paragraph (a)(2) of this Q&A a–4 must be taken into account by such alternate payee for purposes of calculating the excess distributions received by (or excess accumulations held by) the alternate payee.

a–5: Q. If an annuity contract that represents an irrevocable commitment to provide an employee's benefits under the plan is distributed to an individual, how are the distribution of such annuity contract and distributions of amounts under such a contract taken into account for purposes of calculating excess distributions?

A. Except to the extent that the value of an annuity contract is includible in income in the year the contract is distributed or any subsequent year, the distribution of an annuity contract (including a group annuity contract) in satisfaction of plan liabilities is disregarded for purposes of calculating excess distributions. Any amounts that are actually distributed under the contract to the individual (to the extent not excluded under Q&A a–4 of this section) or are otherwise includible in income with respect to the contract (*e.g.*, by reason of the inclusion in income of the value of the annuity contract in the year of the contract's distribution or any subsequent year) are taken into account for purposes of calculating excess distributions for the calendar year during which such amounts are received or otherwise includible in income. For purposes of this Q&A a–5, the term *plan* means any qualified employer plan or individual retirement plan specified in section 4981A(e) and Q&A a–3 of this section.

a–6: Q. Are minimum distributions required under section 401(a)(9), 408(a)(6), 408(b)(3) or 403(b)(10) taken into account to determine excess distributions?

A. Yes. Distributions received during a calendar year are taken into account in determining an individual's excess distributions for such calendar year even though such distributions are required under section 401(a)(9), 408(a)(6), 408(b)(3) or 403(b)(10). For example, minimum distributions under section 401(a)(9) received during the 1987 calendar year for calendar years 1985 and 1986 will be subject to section 4981A as distributions for 1987.

a–7: Q. Are distributions of excess deferrals permitted under section 402(g)(2), or distributions of excess contributions or excess aggregate contributions permitted under section 401(k) or (m), or distributions of IRA contributions permitted under section 408(d) (4) or (5) taken into account for

purposes of calculating excess distributions?

A. No. Distributions of excess deferrals, excess contributions, excess aggregate contributions, distributions of IRA contributions, and income allocable to such contributions or deferrals, that are made in accordance with the provisions of sections 402(g)(2), 401(k)(8), 401(m)(6), or 408(d) (4) or (5) are not taken into account for purposes of calculating excess distributions.

a–8: Q. What distributions from qualified employer plans or individual retirement plans are taken into account in determining an individual's excess distributions?

A. With the exception of distributions noted above in Q&As a–4, a–5, and a–7 of this section, all distributions from qualified employer plans or individual retirement plans must be taken into account in determining an individual's excess distributions for the calendar year in which such distributions are received. In general, all such distributions are taken into account whether or not they are currently includible in income. Thus, for example, net unrealized appreciation in employer securities described in section 402(a) is taken into account in the year distributed. However, health coverage or distributions of medical benefits provided under an arrangement described in section 401(h) that are excludible from income under section 104, 105, or 106 are not subject to section 4981A. In addition, distributions that are excludible from income because they are rolled over to a plan or an individual retirement account are not taken into account. (See Q&A a–4(a) (4) and (5) of this section). Amounts that are includible in income for a calendar year are treated as distributions and, thus, are taken into account even if the amounts are not actually distributed during such year. Thus, deemed distributions to provide insurance coverage includible in income under section 72 (PS–58 amounts), loan amounts treated as deemed distributions under section 72(p), and amounts includible under section 402(b) or section 403(c) by reason of the employer plan or individual retirement plan not being qualified during the year are taken into account.

a–9: Q. Will the dollar threshold amount used to determine an individual's excess distributions be adjusted for inflation in calendar years after 1987?

A. Beginning in 1988, the $112,500 threshold amount is adjusted to reflect post-1986 cost-of-living increases (COLAs) at the same time and in the same manner as the adjustment described in section 415(d). The threshold amount is adjusted even though the distribution is from a defined contribution plan that is subject to a freeze on COLAs because the defined benefit plan limit is below $120,000 (see section 415(c)(1)(A)). However, the $150,000 threshold amount is not adjusted to reflect such increases.

b. Special Grandfather Rule

b–1: Q. How are benefits accrued before TRA '86 treated under the excise tax provisions described in section 4981A?

A. (a) *Grandfather amount.* Certain eligible individuals may elect to use a special grandfather rule that exempts from the excise tax the portion of distributions treated as a recovery of such individual's total benefits accrued on or before August 1, 1986 (grandfather amount). However, distributions that are treated as a recovery of the grandfather amount are taken into account in determining the extent to which other distributions are excess distributions (see Q&A b–4 of this section). Under this special grandfather rule, the grandfather amount equals the value of an individual's total benefits (as described in Q&As b–8 and b–9 of this section) in all qualified employer plans and individual retirement plans on August 1, 1986. An individual's benefits in such plans include amounts determinable on August 1, 1986, that are payable to the individual under a qualified domestic relations order within the meaning of section 414(p) (QDRO). However, QDRO benefits that, when destributed, are includible in the income of the alternate payee are not included in the employee's grandfathered amount. Further, plan benefits that are attributable to a deceased individual and that are payable to an eligible individual as a beneficiary are generally not included in determining the

eligible individual's grandfather amount. Procedures for determining the grandfather amount are described in Q&As b–11 through b–14 of this section.

(b) *Recovery of grandfather amount.* The portion of any distribution made after August 1, 1986, that is treated as a recovery of a grandfather amount depends on which of two grandfather recovery methods the individual elects. The two alternative methods are described in the Q&As b–11 through b–14 of this section. The amount of the distribution for a year that is treated as a recovery of a grandfather amount in a year is applied to reduce the individual's unrecovered grandfather amount for future years (*i.e.,* the individual's accrued benefits as described in Q&As b–8 and b–9 on August 1, 1986, reduced by previous distributions treated as a recovery of a grandfather amount) on a dollar for dollar basis until the individual's unrecovered grandfather amount has been reduced to zero. When the individual's grandfather amount has been reduced to zero, the special grandfather rule ceases to apply and the entire amount of any subsequent excess distributions received is subject to the 15 percent excise tax.

b–2: Q. Who may elect to use the special grandfather rules?

A. Any individual whose accrued benefits as described in Q&As b–8 and b–9 of this section in all qualified plans and individual retirement plans on August 1, 1986 (initial grandfather amount) have a value of at least $562,500 may elect to use the special grandfather rule.

b–3: Q. How does an eligible individual make a valid election to use the special grandfather rule?

A. (a) *Form of election.* An individual who is eligible to use the special grandfather rule must affirmatively elect to use that rule. The election is made on a Form 5329 filed with the individual's income tax return (Form 1040, etc.) for a taxable year beginning after December 31, 1986, and before January 1, 1989 (*i.e.,* the 1987 or 1988 taxable year).

(b) *Information required.* The individual must report the following information on the Form 5329:

(1) The individual's initial grandfather amount.

(2) The grandfather recovery method to be used.

(3) Such other information as is required by the Form 5329.

(c) *Deadline for election.* The deadline for filing such election is the due date, calculated with extensions, for filing the individual's 1988 income tax return. If an individual dies before the expiration of such deadline, an election, or the revocation of a prior election, may be made as part of the final income tax return filed on behalf of such deceased individual by the deceased individual's personal representative. An election or revocation of a prior election may also be filed before the expiration of such deadline with Schedule S (Form 706). See Q&A c–7 of this section.

(d) *Revocation of election.* Elections filed before the deadline may be revoked by filing an amended income tax return for any applicable year. A change in the grandfather recovery method is considered a revocation of a prior election and an amended Form 5329 must be filed for any prior year in which a different grandfather recovery method was used. Thus, a change in the election may require a change in the 1987 tax return. An individual must refile for 1987 based on the new election if additional tax is owed. However, an election (or nonelection) is irrevocable after the filing deadline for the taxable year beginning in 1988 has passed. Thus, an individual who has not made an election by the last day plus extensions for filing the 1988 return may not do so through an amended return.

(e) *Subsequent years.* (1) Any eligible individual who has elected the special grandfather rule must attach to the individual's income tax return for all subsequent taxable years in which the individual receives excess distributions (determined without regard to the grandfather rule) a copy of the Form 5329 on which the individual elected the grandfather rule. A copy of the Form 5329 on which the individual (or the individual's personal representative) elected the grandfather rule must also be filed with Schedule S (Form 706) unless the initial election is filed with such schedule.

(2) The individual must also make such other reports in the form and at

the time as the Commissioner may prescribe. See Q&A c–7 of this section for the applicable reporting requirements if the individual or the individual's estate is liable for any tax on excess distributions or on an excess accumulation under section 4981A (a) or (d).

b–4: Q. How individuals who have elected to use the special grandfather rule determine the extent to which their distributions for any calendar year are excess distributions?

A. (a) *Excess distributions under grandfather rule, threshold amount*. Individuals who elect to use the special grandfather rule are not eligible to use the $150,000 threshold amount in computing their excess distributions for any calendar year. Instead, such electing individuals must compute their excess distributions for a calendar year using a $112,500 (indexed for cost-of-living increases) threshold amount. The rule of this paragraph (a) applies for all calendar years, including the calendar year in which an individual's unrecovered grandfather amount has been reduced to zero and all subsequent calendar years. Once the indexed amount has increased to $150,000 or more, the threshold amount will be the same for all individuals.

(b) *Base for excise tax under grandfather rule*. Although the portion of any distribution that is treated as a recovery of an individual's grandfather amount is not subject to the excise tax, such portion must be taken into account in determining the extent to which the individual has excess distributions for a calendar year. The effect of this rule is that the amount against which the 15 percent excise tax is applied for any calendar year during which a grandfather amount is recovered equals the individual's distributions for such year reduced by the greater of (1) the applicable threshold amount for such year or (2) the grandfather amount recovered for such year. (See the examples in Q&A b–14 of this section.)

b–5: Q. How is the value of an individual's total accrued benefits on August 1, 1986, calculated for purposes of determining (a) whether an individual is eligible to elect the special grandfather rule and (b) the amount of any electing individual's initial grandfather amount under such rule?

A. (a) *Introduction*. The value of an individual's total accrued benefits on August 1, 1986, is the sum of the values of the individual's accrued benefits on such date under all qualified employer plans or individual retirement plans, as determined under the Q&A b–5. If such value exceeds $562,500, the individual may elect the special grandfather rule. In such case, the value so determined may be applied against distributions as determined under this section, whether or not such distributions are from the same plan or IRA for which such grandfather amount is determined. For purposes of determining the value of accrued benefits on August 1, 1986, an annuity contract or an individual's interest in a group annuity contract described in Q&A a–5 of this section is treated as an accrued benefit under the qualified retirement plan or IRA from which it was distributed and an IRA is treated as a defined contribution plan.

(b) *Defined benefit plan*—(1) *General rule*. The amount of an individual's accrued benefit on August 1, 1986, under a defined benefit plan is determined as of that date under the provisions of the plan based on the individual's service and compensation on that date. The present value of such benefit is determined by an actuarial valuation of such accrued benefit performed as of August 1, 1986. Alternatively, accrued benefits may be determined as of July 31, 1986. In such case, the applicable rules are applied by substituting the July 31 date for the August 1 date in the applicable provisions. (See Q&A b–9 of this section for rules for determining the amount of benefits and values and the actuarial assumptions to be used in such determination.)

(2) *Alternative method*. Alternatively, the present value of an individual's accrued benefit on August 1, 1986, may be determined using the following method:

(i) Determine the amount of the individual's actual accrued benefit (prior benefit) on the valuation date that immediately precedes August 1, 1986 (prior date). The valuation date for purposes of using this alternative method is the valuation date used for purposes of section 412. In making this

determination, plan amendments that are adopted after that prior date are disregarded.

(ii) Determine the amount of the individual's adjusted accrued benefit (adjusted prior benefit) on the prior date by reducing the prior benefit in paragraph (b)(2)(i) of this Q&A b–5 by the amount of distributions that reduce the accrued benefit or transfers from the plan and by increasing the prior benefit in paragraph (b)(2)(i) of this Q&A b–5 by any increase in benefit resulting from either transfers to the plan or plan amendments that were made (or, in the case of a plan amendment, both adopted and effective) after the prior valuation date, but on or before August 1, 1986.

(iii) Determine the amount of the individual's actual accrued benefit (future benefit) on the valuation date immediately following August 1, 1986 (next date). In making this determination, plan amendments, etc. that are either adopted or effective after August 1 are disregarded.

(iv) Determine the amount of the individual's adjusted accrued benefit (adjusted future benefit) on the next date by increasing the future benefit in paragraph (b)(2)(iii) of this Q&A b–5 by the amount of any distributions that reduce the accrued benefit or transfers from the plan and by reducing the future benefit in paragraph (b)(2)(iii) of this Q&A b–5 by the amount of any transfer to the plan that was made after August 1, 1986, but on or before the next valuation date to the amount in paragraph (b)(2)(iii) of this Q&A b–5.

(v) Calculate the weighted average of paragraphs (b)(2)(ii) and (b)(2)(iv) of this Q&A b–5, where the weights applied are the number of complete calendar months separating the applicable prior date and the applicable next date, respectively, and August 1, 1986.

(vi) Determine the actuarial present value of the benefit in paragraph (b)(2)(v) of this Q&A b–5 as of August 1, 1986, using the methods and assumptions described in Q&A b–9 of this section.

The grandfather amount on August 1, 1986, attributable to the accrued benefits under the defined benefit plan is equal to the amount determined in paragraph (b)(2)(vi) of this Q&A b–5.

(3) *Certain insurance plans treated as defined contribution plans.* (i) Accrued benefits not in pay status under a plan satisfying the requirements of section 411(b)(1)(F) are determined under the rules in paragraph (c) of this Q&A b–5 for defined contribution plans. For purposes of applying paragraph (c) of this Q&A b–5 to such benefits, the cash surrender value of the contract is substituted for the account balance. If accrued benefits are in pay status under such a plan, the rules of this paragraph (b) apply to such benefits.

(ii) Accrued benefits not in pay status that are attributable to voluntary employee contributions (including rollover amounts) to a defined benefit plan are determined under the rules in paragraph (c) of this Q&A b–5 as if the account balance attributable thereto is under a defined contribution plan. If such benefits are in pay status and are used to fund the benefit under the defined plan, the rules of this paragraph (b) apply to such benefits.

(c) *Defined contribution plan*—(1) *General rule.* The value of an individual's accrued benefit on August 1, 1986, under a defined contribution plan (including IRAs) is the value of the individual's account balance on such date (or on the immediately preceding day). Paragraph (b)(3) of this Q&A b–5 requires that benefits derived from certain insured plans and from voluntary contributions to a defined benefit plan be determined under the rules of this paragraph (c).

(2) *Alternative method.* Alternatively, if a valuation was not performed as of August 1, 1986 (or as of the immediately preceding day), the value of an individual's accrued benefit may be determined as follows:

(i) Determine the value of the individual's account balance on the valuation date immediately preceding August 1, 1986 (prior valuation date).

(ii) Determine the value of the individual's adjusted account balance on the prior valuation date by subtracting (or adding, respectively) the amount of any distribution, including a transfer to another plan or a forfeiture from the account balance (or the amount of any allocation to the account balance, including a transfer from another plan,

rollover received or forfeiture from another account) that was made after the prior valuation date but on or before August 1, 1986, from (or to) the amount in paragraph (c)(2)(i) of this Q&A b–5.

(iii) Determine the value of the individual's account balance on the valuation date immediately following August 1, 1986 (next valuation date).

(iv) Determine the value of the individual's adjusted account balance on the next valuation date by adding (or subtracting, respectively) the amount of any distribution, of a type described in paragraph (c)(2)(ii) of this Q&A b–5 (or the amount of any allocation to the account balance, of a type described in paragraph (c)(2)(ii) of this Q&A b–5), that was made after August 1, 1986, but on or before the next valuation date to (or from) the amount in paragraph (c)(2)(iii) of this Q&A b–5.

(v) Calculate the weighted average of paragraphs (c)(2)(ii) and (c)(2)(iv) of this Q&A b–5, where the weights applied are the number of complete calendar months separating the applicable valuation date and the applicable next date, respectively, and August 1, 1986.

The grandfather amount on August 1, 1986, attributable to the account balance in the defined contribution plan or the individual retirement plan is the amount in paragraph (c)(2)(v) of this Q&A b–5.

b–6: Q. For purposes of determining the value of accrued benefits in a defined contribution plan or a defined benefit plan on August 1, 1986, are nonvested benefits taken into account?

A. Yes. All accrued benefits, whether or not vested, are taken into account.

b–7: Q. To what extent are benefits payable with respect to an individual under a qualified employer plan or an individual retirement plan not taken into account for purposes of calculating the individual's grandfather amount?

A. (a) *Exclusions.* The following benefits payable with respect to an individual are not taken into account for purposes of this calculation:

(1) Benefits attributable to investment in the contract as defined in section 72(f). However, amounts attributable to deductible employee contributions (as defined in section 72(o)(5)(A)) are considered part of the accrued benefit.

(2) Amounts that are determinable on August 1, 1986, as payable to an alternate payee who is required to include such amounts in gross income (a spouse or former spouse) under a qualified domestic relations order (QDRO) within the meaning of section 414(p).

(3) Amounts that are attributable to IRA contributions that are distributed pursuant to section 408(d) (4) or (5).

(b) *Alternate payee.* Under a QDRO described in paragraph (a)(2) of this Q&A b–7, amounts are considered part of the accrued benefit of the alternate payee for purposes of calculating the value of the alternate payee's accrued benefit on August 1, 1986. Similarly, such amounts are used by the alternate payee to compute excess distributions.

b–8: Q. What adjustments to the grandfather amount are necessary to take into account rollovers from one qualified employer plan or individual retirement plan to another such plan?

A. (a) *Rollovers outstanding on valuation date.* Generally, rollovers between plans result in adjustment to the grandfather amounts under the rules in Q&A b–5 of this section. However, if a rollover amount is distributed from one plan on or before an applicable valuation date of such plan and is rolled over into the receiving plan after the receiving plan's applicable valuation date and if these events result in an inappropriate duplication or omission of the rollover amount, then an adjustment to the grandfather amount must be made to remove the duplication or omission. The Commissioner may provide necessary rules concerning this adjustment.

(b) *Valuation.* If the rollover amount described in paragraph (a) of this Q&A b–8 is in a form of property other than cash, the property of which the outstanding rollover consists is valued as of the date the rollover contribution is received by the transferee qualified employer plan or individual retirement plan and that value is the amount of the rollover. If the outstanding rollover is in the form of cash, the amount of the cash is the amount of the rollover.

b–9: Q. What is the form of the grandfather benefit under a defined benefit plan and how is it valued?

A. (a) *Benefit form*. The grandfather amount under a defined benefit plan is determined on the basis of the form of benefit (including any subsidized form of benefit such as a subsidized early retirement benefit or a subsidized joint and survivor annuity) provided under the plan as of August 1, 1986 that has the greatest present value as determined in paragraph (b) of this b–9. If the plan provides a subsidized joint and survivor annuity, for purposes of determining the grandfather amount, it will be assumed that an unmarried individual is married and that the individual spouse is the same age as the individual. Assumptions as to future withdrawals, future salary increases or future cost-of-living increases are not permitted.

(b) *Value of grandfather amount*. The grandfather amount under a defined benefit plan is the present value of the individual's benefit form determined under paragraph (a) of this Q&A b–9. Thus, the benefit form is reduced to reflect its value on the applicable valuation date. The present value of the benefit form on August 1, 1986, or the applicable date, is computed using the factors specified under the terms of the plan as in effect on August 1, 1986, to calculate a single sum distribution if the plan provides for such a distribution. If the plan does not provide for such a distribution form, such present value is computed using the interest rate and mortality assumptions specified in § 20.2031–7 of the Estate Tax Regulations.

b–10: Q. Is the plan administrator (or trustee) of a qualified plan (or individual retirement account) required to report to an individual the value of the individual's benefit under the plan as of August 1, 1986?

A. (a) *Request required*. No report is required unless the individual requests a report and the request is received before April 15, 1989. If requested, the plan administrator (or trustee or issuer) must report to such individual the value of the individual's benefit under the plan as of August 1, 1986, determined in accordance with Q&A b–5 through b–9 of this section. Such report must be made within a reasonable time after the individual's request but not later than July 15, 1989.

(b) *Other rules*. Alternate payees must make their own request for valuation reports. Any report furnished to an employee who has an alternate payee with respect to the plan must include the separate values attributable to each such individual. Any report furnished to an alternate payee must include only the value attributable to the alternate payee. Reports may be furnished to individuals even if no request is made. Individuals must keep records of the reports received from plans or IRAs in order to substantiate all grandfather amounts.

(c) *Authority*. The rules in this Q&A are provided under the authority in section 6047(d).

b–11: Q. How is the portion of a distribution that is treated as a recovery of an individual's grandfather amount as described in b–1 of this section to be calculated?

A. (a) *General rule*. All distributions received between August 1 and December 31, 1986, inclusive, are treated as a recovery of a grandfather amount. The portion of distributions received after December 31, 1986, that is treated as a recovery of the grandfather amount is determined under either the discretionary method or the attained age method. An amount that is treated as a recovery of grandfather benefits is applied to reduce the initial grandfather amount that was calculated as of August 1, 1986, on a dollar for dollar basis until the unrecovered amount has been reduced to zero. No other recalculation of the grandfather amount is to be made for a date after August 1, 1986.

(b) *Methods, etc*. The grandfather amount may be recovered by an individual under either the discretionary method or the attained age method. After the individual's total grandfather amount is treated as recovered under either method, the tax on excess distributions and excess accumulations is determined without regard to any grandfather amount.

b–12: Q. Under the discretionary method, what portion of each distribution is treated as a return of the individual's grandfather amount?

A. (a) *Initial percentage.* Under the discretionary method, unless the individual elects in accordance with paragraph (b) below, 10 percent of the total distributions that the individual receives during any calendar year is treated as a recovery of the grandfather amount.

(b) *Acceleration.* The individual may elect to accelerate the rate of recovery to 100 percent of the total aggregate distributions received during a calendar year commencing with any calendar year, including 1987 (acceleration election). In such case, the rate of recovery is accelerated to 100 percent for the calendar year with respect to which the election is made and for all subsequent calendar years.

(c) *Election.* To recover the grandfather amount using the discretionary method, an individual must elect to use such method when making the election to use the special grandfather rule on the Form 5329. (See Q&A b–3 of this section.) The acceleration election must be made for the individual's taxable year beginning with or within the first calendar year for which such election is made and must be filed with the individual's income tax return for that year. Such acceleration election may also be made or revoked retroactively on an amended return for such year. However, the acceleration election may not be made after the individual's death other than with the individual's final income tax return or with a return for a prior year for which a return was not filed before the individual's death. Thus, the acceleration election may not be made on an amended return filed after the individual's death for a year for which a return was filed before the individual's death. The preceding two sentences shall not apply to deaths occurring in 1987 or 1988. The estate is entitled to use the remaining grandfather amount to determine if there is an excess accumulation. See Q&A d–3 of this section. The acceleration election shall be made on such form and in such manner as the Commissioner prescribes in a manner consistent with the rules of this section.

b–13: Q. Under the attained age method, what portion of each distribution is treated as a return of the individual's grandfather amount?

A. Under the attained age method, the portion of total distributions received during any year that is treated as a recovery of an individual's grandfather amount is calculated by multiplying the individual's aggregate distributions for a calendar year by a fraction. The numerator of the fraction is the difference between the individual's attained age in completed months on August 1, 1986, and the individual's attained age in months at age 35 (420 months). The denominator of the fraction is the difference between the individual's attained age in completed months on December 31 of the calendar year and the individual's attained age in months at age 35 (420 months). An individual whose 35th birthday is after August 1, 1986, may not use the attained age method.

b–14: Q. How is the 15 percent tax with respect to excess distributions for a calendar year calculated by an individual who has elected to use the special grandfather rule?

A. The calculation of the excise tax may be illustrated by the following examples:

Example 1. (a) An individual (A) who participates in two retirement plans, a qualified defined contribution plan and a qualified defined benefit plan, has a total value of accrued benefits on August 1, 1986 under both plans of $1,000,000. Because this amount exceeds $562,500, A is eligible to elect to use the special grandfather rule to calculate the portion of subsequent distributions that are exempt from tax. A elects to use the discretionary grandfather recovery method and attaches a valid election to the 1987 income tax return. A does not elect to accelerate the rate of recovery for 1987. On October 1, 1986, A receives a distribution of $200,000. On February 1, 1987, A receives a distribution of $45,000 and, on November 1, 1987, receives a distribution of $200,000. The 15 percent excise tax applicable to aggregate distributions in 1987 is calculated as follows:

(1) Value of grandfather amount on 8/1/86 ..... $1,000,000
(2) Grandfather amounts recovered in 1986 but after 8/1/86 ..... $200,000
(3) Value of grandfather amount on 12/31/86 ((1)−(2)) $800,000
(4) Grandfather recovery percentage 10%
(5) Distributions between 1/1/87 and 12/31/87 ($45,000×$200,000) $245,000
(6) Portion of (5) exempt from tax ((4)×(5)) $24,500
(7) Amount potentially subject to tax

((5) − (6))
(8) Portion of aggregate distributions in excess of $112,500 ($45,000×$200,000 − $112,500) $132,500
(9) Amount subject to tax (lesser of (7) and (8)) $132,500
(10) Amount of tax (15% of (9)) $19,875
(11) Remaining undistributed value of grandfather amount as of 12/31/87 ((3) − (6)) $775,500

(b) In 1988, A receives no distributions from either plan. On February 1, 1989, A receives a distribution of $300,000 and on December 31, 1989, receives a distribution of $75,000. A makes a valid acceleration election for the 1989 taxable year, whereby A accelerates the rate of grandfather recovery that will apply for calendar years after 1988 to 100 percent. Assume the annual threshold amount for the 1989 calendar year is $125,000 (i.e., 112,500 indexed). The 15 percent excess tax applicable to distributions in 1989 is calculated as follows:

(1) Value of grandfather amount on 8/1/86 ..... $775,500
(2) Grandfather recovery percentage designated for 1989 calendar year 100%
(3) Distributions between 1/1/89 and 12/31/89 ($300,000×$75,000) $375,000
(4) Portion of (3) exempt from tax (2)x(3) $375,000
(5) Amount potentially subject to tax ((3) − (4)) $0
(6) Portion of aggregate distributions in excess of $125,000 ($300,000×$75,000 − $125,000) $250,000
(7) Amount subject to tax (lesser of (5) and (6)) $0
(8) Amount of tax (15% of (7)) $0
(9) Remaining undistributed value of grandfather amount as of 12/31/89 ((1) − (4)) $400,500

The entire amount of any distribution for subsequent calendar years will be treated as a recovery of the grandfather amount and applied against the grandfather amount until the unrecovered grandfather amount is reduced to zero.

Example 2. The facts are the same as in *Example 1* except that A elects to use the attained age recovery method and A makes a valid election for the 1987 taxable year. Further assume that A's attained age in months on August 1, 1986 is 471 months and on December 31, 1987, is 488 months. The 15 percent excise tax applicable to aggregate distributions in 1987 is calculated as follows:

(1) Value of grandfather amount on 8/1/86 ..... $1,000,000
(2) Grandfather amounts recovered in 1986 but after 8/1/86 ..... $200,000
(3) Value of grandfather amount on 12/31/86 ((1) − (2)) $800,000
(4) Completed months of age in excess of 420 on 8/1/86 51
(5) Completed months of age in excess of 420 on 12/31/87 68
(6) Grandfather fraction as of 12/31/86 ((4) divided by (5)) ..... ¾
(7) Distributions between 1/1/87 and 12/31/87 ($45,000 + $200,000) $245,000
(8) Portion of (7) exempt from tax ((6)×(7)) $183,750
(9) Amount potentially subject to tax ((7) − (8)) $61,250
(10) Portion of aggregate distributions in excess of $112,500 ($45,000 + $200,000 − $112,500) $132,500
(11) Amount subject to tax (lesser of (9) and (10)) $61,250
(12) Amount of tax (15% of (11) $9,187
(13) Unrecovered grandfather amount as of 12/31/87 ((3) − (8)) $616,250

c. Special Rules

c-1: Q. How is the excise tax computed if a person elects special tax treatment under section 402 or 403 for a lump sum distribution?

A. (a) *General rule*—(1) *Conditions.* Section 4981A(c)(4) provides for a special tax computation that applies to an individual in a calendar year if the individual receives distributions that include a lump sum distribution and the individual makes certain elections under section 402 or 403 with respect to that lump sum distribution (lump sum election).

(2) *Lump sum election.* A lump sum election includes an election of (i) 5-year income averaging under section 402(e)(4)(B); (ii) phaseout capital gains treatment under sections 402(a)(2) or 403(a)(2) prior to their repeal by section 1122(b) of TRA '86 and as permitted under section 1122(h)(4) of TRA '86; (iii) grandfathered long-term capital gains under sections 402(a)(2) and 403(a) prior to such repeal and as permitted by section 1122(h)(3) of TRA '86; and (iv) grandfathered 10-year income averaging under section 402(e) (including such treatment under a section 402(e)(4)(L) election) prior to amendment by section 1122(a) of TRA '86 and as permitted by section 1122(h)(3)(A)(ii) and (5) of the TRA '86.

(3) *Special tax computation.* (i) If the conditions in paragraph (a)(1) of this Q&A c-1 are satisfied for a calendar year, the rules of this subparagraph (a)(3) apply for purposes of determining whether there are excess distributions and tax under section 4981A.

(ii) All distributions are divided into two categories. These two categories are the lump sum distribution and other distributions. Whether or not a particular distribution is a distribution subject to section 4981A and is in either category is determined under the rules in section 4981A and this section. Thus, the exclusions under section 4981A(c)(2) and Q&A a-4(a) of this section apply here. For example, a distribution that is a tax-free recovery of employee contributions is not in either category.

(iii) The excise tax under section 4981A(c)(1) is computed in the normal manner except that (A) it is the sum of the otherwise applicable taxes determined separately for the two categories of excess distributions and (B) a different amount (threshold amount) is subtracted from the distributions in each category in determining the amount of the excess distributions. The threshold amount that is subtracted from the portion of the distributions that is not part of the lump sum distribution is the applicable threshold amount, determined without regard to section 4981A(c)(4) and the lump sum election. Thus, the threshold amount subtracted from the amount in this category is either the $150,000 amount or the $112,500 amount (indexed). The threshold amount that is subtracted from the amount of the lump sum distribution is 5 times the applicable threshold amount as described above. Thus, the threshold amount subtracted from the lump sum distribution is $750,000 or 5 times $112,500 indexed (initially $562,500).

(b) *Grandfather rule*—(1) *In general.* This paragraph (b) provides special rules where an individual makes both the grandfather election described in section 4981A(c)(5) and the lump sum election described in paragraph (a) of this Q&A c-1. See Q&A b-11 through 14 for other rules that apply to such grandfather election.

(2) *Discretionary method.* If the individual uses the discretionary method, described in Q&As b-11 and 12 of this section, the applicable threshold amount is $112,500 (indexed). Under this method, the grandfather amount is recovered at a 10 percent or 100 percent rate in any calendar year and is offset separately against distributions in each category of distributions at the appropriate rate. If, for any calendar year, distributions are received in both categories and the total of the appropriate percentage (10 percent or 100 percent) of the distributions in each category exceed the unrecovered grandfathered account, then such grandfather amount must be recovered ratably from the distributions in each category. This rule applies even if the distributions in one category are less than the threshold amount for that category and the distributions in the other category exceed the threshold amount for that category.

(3) *Attained age method.* If the individual uses the attained age method, described in Q&As b-11 and 13 of this section, the threshold amount is $112,500 (indexed). Under this method, to determine the portion of the distributions in each category that is treated as a recovery of the grandfather amount, the fraction described in Q&A b-13 of this section is applied separately to the distributions in each category of distributions. If, for any calendar year, distributions are received in both categories and the total of the amounts of the distributions in each category that are treated as a recovery of the grandfather amount exceeds that undercovered grandfather amount, then such grandfather amount must be recovered ratably from the distributions in each category. This rule applies even if the distributions in one category are less than the threshold amount for that category and the distributions in the other category exceed the threshold amount for that category.

(c) *Amount in lump sum category.* All amounts received from the employer that are required to be distributed to the individual in order to make a lump sum election described in paragraph (a) of this Q&A c-1 are included in the lump sum category. Amounts are in the lump sum category even though they are not subject to income tax under the election. Thus, for example, the following amounts would be in the lump sum category: (1) Appreciation on employer securities received as part of a distribution for which a lump sum treatment is elected; and (2) amounts that are phased out when section 1122

of TRA '86 is elected. However, accumulated deductible employee contributions under the plan (within the meaning of section 72(o)(5)) are in the nonlump sum category.

(d) *Examples.* The rules in this Q&A c–1 are illustrated by the following examples:

Example (1). (a) On January 1, 199X, individual A who is age 65 and is a calendar year taxpayer receives a lump sum distribution described in section 402(e)(4)(A) from a qualified employer plan (Plan X). A receives no other distribution in 199X. A elects 5-year income averaging under section 402(e)(4)(B) and also elects section 402(e)(4)(L) treatment (treating pre-74 participation as post-1973 participation) on A's income tax return for 199X. Thus, A also makes the lump sum election described in paragraph (a)(2), above. For 199X, the $112,500 threshold amount indexed is $125,000. A does not make a grandfather election so that A's threshold amount is $150,000.

(b) A's distribution from Plan X consists of cash in the amount of $800,000. A has a section 72(f) investment in the contract. A has over the years made after tax contributions to Plan X of $50,000. A's distributions subject to section 4981A equal $750,000 because of the exclusion of A's $50,000 after-tax contributions.

(c) A's distributions consist solely of amounts in the lump sum category. A's threshold amount equals $750,000 under the rules of this paragraph (a)(iii), above, (5 times $150,000). Because A's threshold amount ($750,000) equals the amount of A's distribution from Plan X ($750,000) no part of A's distribution from Plan X is treated as an excess distribution subject to the 15-percent excise tax.

Example (2). (a) Assume the same facts as in *Example (1)*, except that A receives an additional distribution from an individual retirement plan described in section 408(a) (IRA Y) in 199X of $150,000. A has made no nondeductible contributions to IRA Y and all of the $150,000 is a distribution subject to section 4981A.

(b) A's distributions consist of two categories, the lump sum category (Plan X $750,000) and the other than lump sum category (IRA Y $150,000). A separate threshold amount is subtracted from A's IRA Y distribution. This threshold amount equals $150,000 under the rules of this paragraph (a)(3), above, the same initial threshold amount that is applied against the lump sum prior to the multiplication by 5). Because A's threshold amount ($150,000) equals the amount of A's distribution from IRA Y ($150,000), no part of A's distribution from IRA Y would be treated as an excess distribution subject to the 15-percent excise tax.

Example (3). (a) Assume the same facts as in *Example (2)*, except that A's distribution is $825,000 from Plan X, before reduction of $50,000 for employee contributions, instead of $800,000, so that A's distribution subject to section 4981A from Plan X is $775,000. A made a valid grandfather election. Therefore, the applicable threshold amount is $125,000 ($112,500 indexed for 199X). A's unrecovered grandfather amount as of the end of the year preceding 199X is $1,000,000 (A had a benefit under another retirement plan (Plan Z) on August 1, 1986, and A's account balance under Plan Z, which is a stock bonus plan, is $6,000,000 on January 1, 199X.) A also made a valid election of the discretionary method to recover A's grandfather amount.

(b) If A recovers A's grandfather amount in 199X at the 10 percent rate, 10 percent of A's distributions that are in the lump sum category (Plan X $775,000) is treated as a recovery of A's grandfather amount. Similarly, 10 percent of A's distributions that are in the other than lump sum category (IRA Y $150,000) is treated as a recovery of A's grandfather amount. Thus, A's grandfather amount is reduced by $92,500 ($77,500 Plan X and $15,000 IRA Y) for the 199X calendar year and is $907,500 on January 1 of the year following 199X. Because the amounts of the distributions in each category that are treated as a recovery of grandfather amount are less than the applicable threshold amount for each category ($625,000 Plan X, $125,000 IRA Y), the recovery of the grandfather amount does not affect the calculations of the 199X excise tax.

(c) Because A's distribution from IRA Y of $150,000 exceeds A's threshold amount of $125,000 ($112,500 indexed) applicable to nonlump sum distributions by $25,000 and A's distribution subject to section 4981A from Plan X of $775,000 exceeds A's threshold amount of $625,000 (5X$125,000) applicable to lump sums by $150,000, A is subject to the 15-percent excise tax. A's tax under section 4981A is $26,250 (15 percent of $25,000 plus 15 percent of $150,000).

Example (4). (a) Assume the same facts as in *Example (3)* except that A makes a valid acceleration election under the discretionary method with respect to A's grandfather amount of $1,000,000 for calendar year 199X.

(b) Because A's grandfather amount on January 1, 199X ($1,000,000) equals or exceeds A's distribution subject to section 4981A ($925,000) for 199X, no part of A's distribution from Plan X or IRA Y would be treated as excess distribution subject to the 15-percent excise tax.

(c) A's distributions subject to 4981A from Plan X of $775,000 and from IRA Y of $150,000 are offset 100 percent by A's grandfather

amount of $1,000,000. Therefore, A's grandfather amount on January 1 of the year following 199X is $75,000 ($1,000,000 minus $925,000). This $75,000 would be required to be offset 100 percent against any distributions received in that year.

Example (5). (a) Assume the same facts as in *Example (4)*, except that A's distribution subject to section 4981A from Plan X, after reduction of the $50,000 for employee contributions, is $1,000,000 and from IRA Y is $125,000 (equal to the threshold amount), totaling $1,125,000.

(b) Because the sum of the amount received in the lump sum category and the other than lump sum category of distributions is greater than the grandfather amount ($1,000,000), the grandfather amount must be allocated to each separate category on the basis of the ratio of the amount received in each category to the sum of these amounts. Thus, $888,889 ($1,000,000 X ($1,000,000 divided by $1,125,000)) is allocated to the lump-sum category and $111,111 ($1,000,000 X ($125,000 divided by $1,125,000)) is allocated to the other than lump sum category. A's distributions of $1,000,000 in the lump sum category are reduced by $888,889, the greater of $625,000 (the threshold amount) or $888,889 (grandfather amount), and equal $111,111. A's excise tax is $16,666 (15 percent of $111,111). A owes no excess distribution tax on the $125,000 received from IRA Y because it is fully offset by the threshold amount of $125,000.

(c) Because A's distribution subject to section 4981A for the year of $1,125,000 ($1,000,000 plus $125,000) exceeds A's grandfather amount on January 1, 199X of $1,000,000, A's grandfather amount is zero for all subsequent calendar years.

c–2: Q. Must retirement plans be amended to limit future benefits accruals so that the amounts that are distributed would not be subject to an excise tax under section 4981A?

A. No. A qualified employer plan need not be amended to reduce future benefits so that the amount of annual aggregate distributions are not subject to tax under section 4981A. Section 415 does, however, require plan provisions that limit the accrual of benefits and contributions to specified amounts. The operation of the excise tax of section 4981A is independent of plan qualification requirements limiting benefits and contributions under qualified plans.

c–3: Q. Is a plan amendment reducing accrued benefits a permitted method of avoiding the excise tax?

A. No. Accrued benefits may not be reduced to avoid the imposition of the excise tax. Such reduction would violate employer plan qualification requirements, including section 411(d)(6).

c–4: Q. To what extent is the 15 percent section 4981A tax reduced by the 10 percent section 72(t) tax?

A. (a) *General rule.* The 15 percent tax on excess distributions may be offset by the 10 percent tax on early distributions to the extent that the 10 percent tax is applied to excess distributions. For example, assume that individual (A), age 56, receives a distribution of $200,000 from a qualified employer plan (Plan X) during calendar year 1987. Further, assume that the entire distribution is subject to the 10-percent tax of section 72(t). A tax of $20,000 (10% of $200,000) is imposed on the distribution under section 72(t). Assuming that the distribution is not a lump sum distribution eligible for special tax treatment under section 402, part of the distribution is subject to tax under section 4981A. If A does not elect the special grandfather rule, A's dollar limitation is $150,000 and the amount of $200,000 distribution that is an excess distribution is $50,000 ($200,000–$150,000). The 15 percent tax is $7,500 (15% of $50,000). The portion of the $20,000 section 72(t) tax on early distributions that is attributable to the excess distribution is $5,000 (10% of $50,000). This amount is credited against the section 4981A tax. Therefore, the total tax imposed on the distribution under both provisions is $22,500 ($20,000 + ($7,500–$5,000)).

(b) *Example.* (1) If some, but not all, distributions made for a calendar year are subject to the section 72(t) tax, the offset is applied only to the extent that the section 72(t) tax applies to amounts that exceed the applicable threshold amount for that calendar year. For example, assume that during 1987 individual B receives a distribution of $40,000 that is not subject to the 10 percent section 72(t) tax and a separate distribution of $160,000 that is subject to the 10 percent section 72(t) tax. A tax of $16,000 (10% of $160,000) is imposed by section 72(t). Excess distributions for the year, assuming B does not elect the special grandfather rule, are $50,000 ($40,000 + $160,000–$150,000). The tax under section 4981A is $7,500 (15% of $50,000). For purposes of determining

the extent to which the 10 percent tax is applied to excess distributions, the only amounts subject to the 10 percent tax that are taken into account are distributions in excess of $150,000 (or if greater, the $112,500 (indexed) threshold for the year). The amount of distributions for 1987 to which the 10 percent tax is applicable ($160,000) exceeds $150,000 by $10,000. Thus, the portion of the section 72(t) tax of $16,000 that is attributable to excess distributions equals $1,000 (10 percent of $10,000). This amount is credited against the section 4981A tax. The total tax payable under the provisions of sections 72(t) and 4981A is $22,500 ($16,000 + ($7,500–$1,000)).

(c) *Net unrealized appreciation.* A distribution consisting of net unrealized appreciation of employer securities that is excluded from gross income is not subject to section 72(t) and, therefore, there is no section 72(t) tax on such distribution that may be used to offset the tax on excess distributions.

c–5: Q. If a distribution that is subject to both the 10 percent tax on early distributions from qualified plans imposed under section 72(t) and the 15 percent tax on excess distributions imposed under section 4981A is received by an individual who elects to calculate the 15 percent tax using the special grandfather rule, how is the offset of the 10 percent tax imposed under section 72(t) calculated?

A. The section 4981A tax is reduced only by the amount of the 10 percent tax that is attributable to the portion of the distribution to which the section 4981A tax applies. For example, assume that (a) an individual (A), age 57, receives during 199X a distribution from a qualified plan of $325,000 that is subject to the 10 percent section 72(t) tax; (b) the distribution is not a lump sum distribution and is subject to the 15 percent excise tax imposed by section 4981A; (c) A has elected to use the special grandfather rule; and (d) A accelerates the rate of recovery of the remaining grandfather amount of $250,000 so that only $75,000 of this distribution is subject to the section 4981A tax. Thus, the section 4981A tax is $11,250 (15% of $75,000). The portion of the section 72(t) 10 percent tax that is offset against the section 4981A tax of $11,250 is limited to $7,500 (10% of $75,000), the section 72(t) tax on the amount of distributions after taking into account the reduction under the grandfather rule.

c–6: Q. When do distributions become subject to the excise tax under section 4981A?

A. (a) *General rule.* Excess distributions made after December 31, 1986, are subject to the excise tax under section 4981A.

(b) *Transitional rule*—(1) *Termination.* Distributions prior to January 1, 1988, made on account of certain terminations of a qualified employer plan are not subject to tax under section 4981A. For a plan termination to be eligible for this transitional rule, the plan termination must occur before January 1, 1987. For purposes of applying the rules of section 4981A (except the reporting requirements), any such distribution is treated as if made on December 31, 1986. The distribution of an annuity contract is not an excepted distribution. See Q&A a–5 of this section.

(2) *Lump sum distributions.* A lump sum distribution that an individual who separates from service in 1986 receives in calendar year 1987 before March 16 is treated as a distribution received in 1986 if such individual elects to treat it as received in 1986 under the provisions of section 1124 of TRA '86. Thus, such a qualifying section 1124 distribution is not subject to tax under section 4981A for 1987. For purposes of applying the rules of section 4981A, the amount attributable to such distribution is included in the individual's August 1, 1986 accrued benefit and such distribution is treated as if made on December 31, 1986.

(3) *Grandfather amount recovery.* If an individual described in this paragraph elects the special grandfather rule, the entire amount of distributions described in subparagraph (1) or (2) of this paragraph (b) is treated as a recovery of the individual's grandfather amount because it is treated as received on December 31, 1986. Thus, the individual's outstanding grandfather amount as of the date of the distribution is reduced by the amount of such distribution.

c–7: Q. How is the tax on excess distributions or on excess accumulations under section 4981A reported?

A. (a) *Tax on excess distributions.* An individual liable for tax on account on excess distributions under section 4981A must complete Form 5329 and attach it to his income tax return for the taxable year beginning with or within the calendar year during which the excess distributions are received. The amount of the tax is reported on such form and in such manner as prescribed by the Commissioner.

(b) *Tax on excess accumulations*—(1) *General rule.* If, with respect to the estate of any individual, there is a tax under section 4981A(d) on account of the individual's excess accumulations, the amount of such tax is reported on Schedule S (Form 706 or 706NR). Schedule S must be filed on or before the due date under section 6075 including extensions, for filing the estate tax return. The tax under section 4981A(d) must be paid by the otherwise applicable due date for paying the estate tax imposed by chapter 11 even if, pursuant to section 6018(a), no return is otherwise required with respect to the estate tax imposed by chapter 11.

(2) *Earliest due date.* Notwithstanding paragraph (b)(1) of this c–7, the due date for filing Schedule S (Form 706) and paying the tax on excess accumulations under section 4981A(d) is not earlier than February 1, 1988. Thus, with respect to the estates of individuals dying in January through April of 1987, the due date for filing Schedule S (Form 706) and paying any tax owed under section 4981A(d) is not earlier than February 1, 1988, even if the due date for filing the Schedule 706 and paying the estate tax imposed by chapter 11 is an earlier date. Further, no interest or penalties will be charged for failure to pay any tax on excess accumulations under section 4981A before January 31, 1988.

c–8: Q. Does the fact that the benefits under a qualified retirement plan or individual retirement account are community property affect the determination of the excise tax under section 4981A?

A. Generally, no. The operation of community property law is disregarded in determining the amount of aggregate annual distributions. Thus, the excise tax under section 4981A is computed without regard to the spouse's community property interest in the individual's or decedent's distributions or accumulation. Also, any reporting to the individual by a trustee, must be done on an aggregate basis without regard to the community property law.

d. Excess Accumulations

d–1: Q. To what extent does section 4981A increase the estate tax imposed by chapter 11 with respect to the estates of any decedents?

A. Section 4981A(d) provides that the estate tax imposed by chapter 11 with respect to the estate of any decedent is increased by an amount equal to 15 percent of the decedent's excess accumulation. See Q&A d–2 through d–7 of this section for rules for determining the decedent's excess accumulation. See Q&A d–8 of this section concerning credits under section 2010 through 2016. See Q&A d–9 of this section for examples illustrating the determination of the increase in estate tax under section 4981A(d).

d–2: Q. How is the amount of an decedent's excess accumulation determined?

A. (a) *General rule.* A decedent's excess accumulation is the excess of (1) the aggregate value of the decedent's interests in all qualified employer plans and individual retirement plans (decedent's aggregate interest) as of the date of the decedent's death over (2) an amount equal to the present value of a hypothetical life annuity determined under Q&A d–7 of this section. If the personal representative for the individual's estate elects to value the property in the gross estate under section 2032, the applicable valuation date prescribed by section 2032 shall be substituted for the decedent's date of death.

(b) *Other rules.* See Q&A d–3 and d–4 of this section if the decedent or, where appropriate, the decedent's personal representative validly elects the special grandfather rule and has any unused grandfather benefit as of the date of his death. See Q&A d–5 and d–6 of this section to determine the decedent's aggregate interest.

d–3: Q. Does the special grandfather rule apply for purposes of determining the amount of the decedent's excess accumulation?

A. Yes. If a decedent prior to death (or the decedent's personal representative after death) makes an election that satisfied the procedures in Q&A b–3 of this section, the special grandfather rule applies.

d–4: Q. How is the decedent's excess accumulation determined if the special grandfather rule applies?

A. If the special grandfather rule applies, the decedent's excess accumulation is the excess of (a) the decedent's aggregate interest (determined under Q&A d–5 of this section) over (b) the greater of (1) the decedent's remaining unrecovered grandfather amount as of the date of the decedent's death, or (2) an amount equal to the present value of a hypothetical life annuity under Q&A d–7 of this section.

d–5. Q. How is the value of the decedent's aggregate interest as of the applicable valuation date under Q&A d–2 determined?

A. (a) *Method of valuation.* The value of the decedent's aggregate interest on the decedent's date of death is determined in a manner consistent with the valuation of such interests for purposes of determining the individual's gross estate for purposes of chapter 11. If the personal representative for an individual's estate subject to estate tax elects to value the property in the gross estate under section 2032, the decedent's aggregate interest is valued in a manner consistent with the rules prescribed by section 2032 (and other relevant estate tax sections). No adjustments provided in chapter 11 in valuing the gross estate are made. Thus, there is no adjustment under section 2057 (relating to the sale of certain employer securities).

(b) *Amounts included.* Generally, all amounts payable to beneficiaries of the decedent under any qualified employer plan (including amounts payable to a surviving spouse under a qualified joint and survivor annuity or qualified preretirement survivor annuity) or individual retirement plan, whether or not otherwise included in valuing the decedent's gross estate, are considered to be part of the decedent's interest in such plan.

(c) *Rollover after death.* If any amount is distributed from a qualified employer plan or individual retirement plan within the 60-day period ending on the decedent's date of death and is rolled over to an IRA after such date but within 60 days of the date distributed, the decedent's aggregate interest is increased by the amount rolled over, valued as of the date received by the IRA.

d–6. Q. Are there any reductions in the decedent's aggregate interest?

A. The decedent's aggregate interest is reduced by the following:

(a) *Amount payable to alternate payee.* The amount of any portion of the deceased individual's interest in a qualified employer plan that is payable to an alternate payee in whose income the amount is includible under a qualified domestic relations order within the meaning of section 414(p) (QDRO). However, such portion must be taken into account in determining the excess distribution or the excess accumulation upon the death of such alternate payee for purposes of determining if there is a tax under section 4981A(a) or an increase in the estate tax under section 4981A(d) with respect to such alternate payee.

(b) *Investment in the contract.* The amount of the deceased individual's unrecovered investment, within the meaning of section 72(f), in any qualified employer plan or individual retirement plan.

(c) *Life insurance proceeds.* The excess of any amount payable by reason of the death of the individual under a life insurance contract held under a qualified employer plan over the cash surrender value of such contract immediately before the death of such individual (the amount excludible from income by reason of section 101(a)). Amounts excludible from gross income because of section 101(b) do not reduce the decedent's aggregate interest.

(d) *Interest as a beneficiary.* The amount of the deceased individual's interest in a qualified retirement plan or individual retirement plan by reason of the death of another individual.

d–7. Q. How is the present value of the hypothetical life annuity determined?

A. (a) *General rule.* The hypothetical life annuity is a single life annuity contract that provides for equal annual annuity payments commencing on the

decedent's date of death for the life of an individual whose age is the same as the decedent's determined as of the date of the decedent's death. The amount of each annual payment is equal to the greater of $150,000 (unindexed) and $112,500 (as indexed until the date of death). If the decedent elected (or the decedent's personal representative elects) the special grandfather rule, the amount of each annual payment is $112,500 (as indexed until the date of death) even if there is no remaining grandfather amount.

(b) *Determination of age.* The decedent's age as of the decedent's date of death for purposes of valuing the hypothetical life annuity is the decedent's attained age (in whole years) as of the decedent's date of death. For example, if the decedent was born on February 2, 1930, and died on August 3, 1990, the decedent's age for purposes of valuing the hypothetical life annuity is 60.

(c) *Interest rate assumptions.* The present value of the single life annuity described above must then be calculated using the interest rate and mortality assumptions in §20.2031–7 of the Estate Tax Regulations in effect on the date of death.

d–8: Q. Are any credits, deductions, exclusions, etc. that apply for estate tax purposes allowable as an offset against the excise tax under section 4981A(d) for excess accumulations?

A. No. No credits, deductions, exclusions, etc. that apply for estate tax purposes are allowed to offset the tax imposed under section 4981A(d). Thus, no credits under section 2010 through 2016 or other reductions permitted by Chapter 11 are allowable against the tax under section 4981A(d) for excess accumulations. For example, no credits are allowable for the unified credit against the estate tax, for state death taxes, or for gift taxes.

d–8A. Q. Is the estate liable for the excise tax of 15 percent on the amount of the decedent's excess accumulations?

A. Yes. In all events, the estate is liable for the excise tax of 15 percent on the amount of the decedent's excess accumulations. Transferee liability rules under chapter 11 do apply, however. Similarly, the reimbursement provisions of section 2205 also apply. Additionally, the rules generally applicable for purposes of determining the apportionment of the estate tax apply to the apportionment of the excise tax under section 4981A(d). Thus, the decedent's will or the applicable state apportionment law may provide that the executor is entitled to recover the tax imposed under section 4981A(d) attributable to any property from the beneficiary entitled to receive such property. However, absent such a provision in the decedent's will or in the applicable state apportionment law, the executor is not entitled to recover the tax imposed under section 4981A(d) attributable to any property from the beneficiary entitled to receive such property.

d–9: Q. How is the additional tax computed with respect to a decedent's estate under section 4981A(d)?

A. The determination of the additional tax under section 4981A(d) is illustrated by the following examples:

Example 1. (a) An individual (A) dies on February 1, 199X at age 70 and 9 months. As of A's date of death, A has an interest in a defined benefit plan described in section 401(a) (Plan X). Plan X has never provided for employee contributions. A has no section 72 (f) investment in Plan X. A does not have any interest in any other qualified employer plan or individual retirement plan. The alternate valuation date in section 2032 does not apply. A did not elect to have the special grandfather rule apply. A's interest in Plan X is in the form of a qualified joint and survivor annuity. The value of the remaining payments under the joint and survivor annuity as of A's date of death (determined under D–5) is $2,000,000.

(b) Because A is age 70 and 9 months of A's date of death, A's life expectancy as of A's date of death is calculated using age 70 (A's attained age in whole years on A's date of death). The factor from Table A of §20.2031–7(f) used to determine the present value of a single life annuity for an individual age 70 is 6.0522. The greater of $150,000 or $112,500 indexed for 199X is 150,000. The present value of the hypothetical single life annuity is $907,830 ($150,000 X 6.0522)

(c) The amount of A's excess accumulation is $1,092,170, determined as follows: $2,000,000 (value of A's interest in Plan X) minus $907,830 (value of hypothetical single life annuity contract) equals $1,092,170.

(d) The increase in the estate tax under section 4981A(d) is $163,825 (15 percent of $1,092,170).

Example 2. (a) The facts are the same as in *Example 1*, except that A's interest in Plan X consists of the following:

(1) $2,000,000, value of employer-provided portion of a qualified joint and survivor annuity determined as of A's date of death using the interest and mortality assumptions in § 20.2031–7.

(2) $200,000, proceeds of a term life insurance contract (no cash surrender value before death).

(3) $100,000. amount (employer-provided portion) payable to A's former spouse pursuant to a QDRO.

(4) $100,000, amount of A's investment in Plan X.

(b) The value of A's interest in Plan X for purposes of calculating A's excess accumulation is still $2,000,000. The proceeds of the term life insurance contract, the amount payable under the QDRO, and the amount of A's investment in Plan X are excluded from such value.

Example 3. (a) The facts are the same as in *Example 1*, except that A elected the special grandfather rule. A's initial grandfather amount was $1,100,000. As of A's date of death, A had received $500,000 in distributions that were treated as a return of A's grandfather amount. Thus, A's unused grandfather amount is $600,000 ($1,100,000–$500,000). In 199X, assume that $112,500 indexed is still $112,500.

(b) A's excess retirement accumulation is determined as follows: $2,000,000 minus the greater of (1) $600,000 or (2) the present value of a period certain annuity of $112,500 a year for 16 years. The present value of a single life annuity of $112,500 a year for an individual age 70 is determined as follows: $112,500 × 6.0522=$680,827.25. $680,827.25 is greater than $600,000. Thus the amount of the excess retirement accumulation is $1,319,173 ($2,000,000 minus $680,827).

(c) The additional estate tax under section 4981A(d) is $197,875 (15 percent of $1,319,173).

Example 4. (a) The facts are the same as in *Example 3* except that, as of A's date of death, A received $90,000 in distributions that were treated as a return of A's grandfather amount. Thus, A's unused grandfather amount is $1,010,000 ($1,100,000–$90,000).

(b) A's excess retirement accumulation is determined as follows: $2,000,000 minus the greater of (1) ($1,010,000 (A's unused grandfather amount) or (2) 680,827.25 (the present value of a single life annuity of $112,500 a year for an individual age 70). A's unused grandfather amount is greater than the present value of the hypothetical life annuity. Thus, the amount of the excess retirement accumulation is $990,000 ($2,000,000–$1,010,000).

(c) The additional estate tax under section 4981A(d) is $148,500 (15 percent of $990,000).

d–10: Q. if a surviving spouse rolls over a distribution from a qualified retirement plan or an individual retirement plan of the decedent to an individual retirement plan (IRA) established in the spouse's own name, is any distribution in a calendar year from the IRA receiving such rollover included in determining the spouse's excess distribution or excess accumulation in such calendar year?

A. (a) *General rule.* If a surviving spouse rolls over a distribution from a qualified retirement plan or an individual retirement plan of the decedent to an individual retirement plan (IRA) established in the spouse's own name with the rollover contribution and no other contributions or transfers are made to the IRA receiving the rollover contribution, distributions from such IRA will be excluded in determining the spouse's excess distributions and the value of the IRA will be excluded in determining the spouse's excess accumulation. If the surviving spouse rolls over a distribution from a qualified retirement plan or IRA of the decedent to an IRA for which the spouse has prior contributions or makes additional contributions to the IRA receiving the distribution, distributions from the IRA will be included in determining the amount of the excess distributions received by the spouse for the calendar year of the distribution and the value of the IRA at the applicable valuation date will be included in determining the spouse's excess accumulation.

(b) *Special rules.* The rule in paragraph (a) of this Q&A d–10 also applies if a surviving spouse elects to treat an inherited IRA (described in section 408(d)(3)(C)(ii)) as the spouse's own IRA as long as the surviving spouse makes no further contributions to such IRA.

(c) *Other beneficiaries.* Rules similar to the rules in paragraphs (a) and (b) shall apply to an individual who elected to treat an IRA as subject to the distribution requirements of section 408(a)(6), prior to amendment by section 521(b) of TRA '84, under § 1.408–2(b)(7)(ii) of the Income Tax Regulations.

d–11. Q. To what estates does the excise tax under section 4981A(d) apply?

A. The excise tax under section 4981A(d) applies to estates of decedents dying after December 31, 1986.

d–12: Q. Is the aggregate interest reduced by distributions described in paragraph (b)(1) of Q&A c–6 of this section (distributions prior to January 1, 1988, made on account of certain terminations of a qualified employer plan) which are made after the individual's death.

A. Yes, the value of the individual's aggregate interest determined under Q&A d–5 of this section is reduced by distributions described in paragraph (b)(1) of Q&A c–6 of this section which are made after the individual's death.

[T.D. 8165, 52 FR 46750, Dec. 10, 1987; 53 FR 18975, May 26, 1988]

§ 54.6011–1 General requirement of return, statement, or list.

(a) *Minimum funding standards or excess contributions for self-employed individuals and section 403(b)(7)(A) custodial accounts.* Any employer or individual liable for tax under section 4971, 4972 or 4973(a)(2) (for a custodial account under section 403(b)(7)(A)) shall file an annual return on Form 5330 and shall include therein the information required by such form and the instructions issued with respect thereto.

(b) *Tax on prohibited transactions.* Every disqualified person (as defined in section 4975(e)(2)) liable for the tax imposed under section 4975(a) with respect to a prohibited transaction shall file an annual return on Form 5330 and shall include therein the information required by such form and the instructions issued with respect thereto. The annual return on Form 5330 shall be filed with respect to each prohibited transaction and for each taxable year (or part thereof) of the disqualified person in the taxable period (as defined in section 4975(f)(2)) beginning on the date on which such prohibited transaction occurs.

[T.D. 7838, 47 FR 44249, Oct. 7, 1982]

§ 54.6011–1T General requirement of return, statement, or list (temporary).

Every employer liable for the tax imposed under section 4980(a) with respect to an employer reversion (as defined in section 4980(c)(2)) shall file a quarterly return on Form 5330 and shall include therein the information required by such form and the instructions issued with respect thereto. The quarterly return on Form 5330 shall be filed with respect to employer reversions from each qualified plan (as defined in section 4980(c)(1)).

[T.D. 8133, 52 FR 10563, Apr. 2, 1987]

§ 54.9801–1T Basis and scope (temporary).

(a) *Statutory basis.* Sections 54.9801–1T through 54.9801–6T, 54.9802–1T, 54.9811–1T, 54.9812–1T, 54.9831–1T, and 54.9833–1T (portability sections) implement Chapter 100 of Subtitle K of the Internal Revenue Code of 1986.

(b) *Scope.* A group health plan may provide greater rights to participants and beneficiaries than those set forth in these portability sections. These portability sections set forth minimum requirements for group health plans concerning:

(1) Limitations on a preexisting condition exclusion period.

(2) Certificates and disclosure of previous coverage.

(3) Rules relating to creditable coverage.

(4) Special enrollment periods.

(c) *Similar Requirements under the Public Health Service Act and Employee Retirement Income Security Act.* Sections 2701, 2702, 2704, 2705, 2721, and 2791 of the Public Health Service Act and sections 701, 702, 703, 711, 712, 732, and 733 of the Employee Retirement Income Security Act of 1974 impose requirements similar to those imposed under Chapter 100 of Subtitle K with respect to health insurance issuers offering group health insurance coverage. See 45 CFR parts 144, 146 and 148 and 29 CFR part 2590. See also Part B of Title XXVII of the Public Health Service Act and 45 CFR part 148 for other rules applicable to health insurance offered in the individual market (defined in § 54.9801–2T).

[T.D. 8716, 62 FR 16927, Apr. 8, 1997; 62 FR 31691, June 10, 1997, as amended by T.D. 8741, 62 FR 66952, Dec. 22, 1997; T.D. 8788, 63 FR 57553, Oct. 27, 1998]

§ 54.9801–2T Definitions (temporary).

Unless otherwise provided, the definitions in this section govern in applying the provisions of §§ 54.9801–1T through

54.9801–6T, 54.9802–1T, 54.9811–1T, 54.9812–1T, 54.9831–1T, and 54.9833–1T.

Affiliation period means a period of time that must expire before health insurance coverage provided by an HMO becomes effective, and during which the HMO is not required to provide benefits.

COBRA definitions:

(1) *COBRA* means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

(2) *COBRA continuation coverage* means coverage, under a group health plan, that satisfies an applicable COBRA continuation provision.

(3) *COBRA continuation provision* means sections 601–608 of ERISA, section 4980B of the Code (other than paragraph (f)(1) of such section 4980B insofar as it relates to pediatric vaccines), and Title XXII of the PHSA.

(4) *Exhaustion of COBRA continuation coverage* means that an individual's COBRA continuation coverage ceases for any reason other than either failure of the individual to pay premiums on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). An individual is considered to have exhausted COBRA continuation coverage if such coverage ceases—

(i) Due to the failure of the employer or other responsible entity to remit premiums on a timely basis; or

(ii) When the individual no longer resides, lives, or works in a service area of an HMO or similar program (whether or not within the choice of the individual) and there is no other COBRA continuation coverage available to the individual.

Condition means a medical condition.

Creditable coverage means *creditable coverage* within the meaning of § 54.9801–4T(a).

Employee Retirement Income Security Act of 1974 (ERISA) means the Employee Retirement Income Security Act of 1974, as amended (29 U.S.C. 1001 *et seq.*).

Enroll means to become covered for benefits under a group health plan (i.e., when coverage becomes effective), without regard to when the individual may have completed or filed any forms that are required in order to enroll in the plan. For this purpose, an individual who has health insurance coverage under a group health plan is enrolled in the plan regardless of whether the individual elects coverage, the individual is a dependent who becomes covered as a result of an election by a participant, or the individual becomes covered without an election.

Enrollment date definitions *(enrollment date* and *first day of coverage)* are set forth in § 54.9801–3T(a)(2) (i) and (ii).

Excepted benefits means the benefits described as excepted in § 54.9831–1T(b).

Genetic information means information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

Group health insurance coverage means health insurance coverage offered in connection with a group health plan.

Group health plan means a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.

Group market means the market for health insurance coverage offered in connection with a group health plan. (However, certain very small plans may be treated as being in the individual market, rather than the group market; see the definition of *individual market* in this section.)

Health insurance coverage means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. However, benefits described in § 54.9831–1T(b)(2) are not treated as benefits consisting of medical care.

Health insurance issuer or *issuer* means an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a State and that is subject to State law that regulates insurance (within the meaning of section 514(b)(2) of ERISA). Such term does not include a group health plan.

Health maintenance organization or *HMO* means—

(1) A federally qualified health maintenance organization (as defined in section 1301(a) of the PHSA);

(2) An organization recognized under State law as a health maintenance organization; or

(3) A similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

Individual health insurance coverage means health insurance coverage offered to individuals in the individual market, but does not include short-term, limited duration insurance. For this purpose, short-term, limited duration insurance means health insurance coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer's consent) that is within 12 months of the date such contract becomes effective. Individual health insurance coverage can include dependent coverage.

Individual market means the market for health insurance coverage offered to individuals other than in connection with a group health plan. Unless a State elects otherwise in accordance with section 2791(e)(1)(B)(ii) of the PHSA, such term also includes coverage offered in connection with a group health plan that has fewer than two participants as current employees on the first day of the plan year.

Issuer means a health insurance issuer.

Late enrollment definitions *(late enrollee* and *late enrollment*) are set forth in § 54.9801–3T(a)(2) (iii) and (iv).

Medical care has the meaning given such term by section 213(d) of the Internal Revenue Code, determined without regard to section 213(d)(1)(C) and so much of section 213(d)(1)(D) as relates to qualified long-term care insurance.

Medical condition or *condition* means any condition, whether physical or mental, including, but not limited to, any condition resulting from illness, injury (whether or not the injury is accidental), pregnancy, or congenital malformation. However, genetic information is not a condition.

Placement, or being placed, for adoption means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with such person terminates upon the termination of such legal obligation.

Plan year means the year that is designated as the plan year in the plan document of a group health plan, except that if the plan document does not designate a plan year or if there is no plan document, the plan year is—

(1) The deductible/limit year used under the plan;

(2) If the plan does not impose deductibles or limits on a yearly basis, then the plan year is the policy year;

(3) If the plan does not impose deductibles or limits on a yearly basis, and either the plan is not insured or the insurance policy is not renewed on an annual basis, then the plan year is the employer's taxable year; or

(4) In any other case, the plan year is the calendar year.

Preexisting condition exclusion means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the first day of coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition exclusion includes any exclusion applicable to an individual as a result of information that is obtained relating to an individual's health status before the individual's first day of coverage, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the preenrollment period.

Public health plan means *public health plan* within the meaning of § 54.9801–4T(a)(1)(ix).

Public Health Service Act (PHSA) means the Public Health Service Act (42 U.S.C. 201, *et seq.*).

Significant break in coverage means a *significant break in coverage* within the meaning of § 54.9801–4T(b)(2)(iii).

Special enrollment date means a *special enrollment date* within the meaning of § 54.9801–6T(d).

State health benefits risk pool means a *State health benefits risk pool* within the meaning of § 54.9801–4T(a)(1)(vii).

Waiting period means the period that must pass before an employee or dependent is eligible to enroll under the terms of a group health plan. If an employee or dependent enrolls as a late enrollee or on a special enrollment date, any period before such late or special enrollment is not a waiting period. If an individual seeks and obtains coverage in the individual market, any period after the date the individual files a substantially complete application for coverage and before the first day of coverage is a waiting period.

[T.D. 8716, 62 FR 16928, Apr. 8, 1997; 62 FR 31691, June 10, 1997, as amended by T.D. 8741, 62 FR 66952, Dec. 22, 1997; T.D. 8788, 63 FR 57554, Oct. 27, 1998]

§ 54.9801–3T Limitations on preexisting condition exclusion period (temporary).

(a) *Preexisting condition exclusion*—(1) *In general.* Subject to paragraph (b) of this section, a group health plan may impose, with respect to a participant or beneficiary, a preexisting condition exclusion only if the requirements of this paragraph (a) are satisfied. (See PHSA section 2701 and ERISA section 701 under which this prohibition is also imposed on a health insurance issuer offering group health insurance coverage.)

(i) *6-month look-back rule.* A preexisting condition exclusion must relate to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date.

(A) For purposes of this paragraph (a)(1)(i), medical advice, diagnosis, care, or treatment is taken into account only if it is recommended by, or received from, an individual licensed or similarly authorized to provide such services under State law and operating within the scope of practice authorized by State law.

(B) For purposes of this paragraph (a)(1)(i), the 6-month period ending on the enrollment date begins on the 6-month anniversary date preceding the enrollment date. For example, for an enrollment date of August 1, 1998, the 6-month period preceding the enrollment date is the period commencing on February 1, 1998 and continuing through July 31, 1998. As another example, for an enrollment date of August 30, 1998, the 6-month period preceding the enrollment date is the period commencing on February 28, 1998 and continuing through August 29, 1998.

(C) The rules of this paragraph (a)(1)(i) are illustrated by the following examples:

Example 1. (i) Individual *A* is treated for a medical condition 7 months before the enrollment date in Employer *R*'s group health plan. As part of such treatment, *A*'s physician recommends that a follow-up examination be given 2 months later. Despite this recommendation, *A* does not receive a follow-up examination and no other medical advice, diagnosis, care, or treatment for that condition is recommended to *A* or received by *A* during the 6-month period ending on *A*'s enrollment date in Employer *R*'s plan.

(ii) In this *Example 1*, Employer *R*'s plan may not impose a preexisting condition exclusion period with respect to the condition for which *A* received treatment 7 months prior to the enrollment date.

Example 2. (i) Same facts as *Example 1* except that Employer *R's* plan learns of the condition and attaches a rider to *A*'s policy excluding coverage for the condition. Three months after enrollment, *A*'s condition recurs, and Employer *R*'s plan denies payment under the rider.

(ii) In this *Example 2*, the rider is a preexisting condition exclusion and Employer *R*'s plan may not impose a preexisting condition exclusion with respect to the condition for which *A* received treatment 7 months prior to the enrollment date.

Example 3. (i) Individual *B* has asthma and is treated for that condition several times during the 6-month period before *B*'s enrollment date in Employer *S*'s plan. The plan imposes a 12-month preexisting condition exclusion. *B* has no prior creditable coverage to

reduce the exclusion period. Three months after the enrollment date, *B* begins coverage under Employer *S*'s plan. Two months later, *B* is hospitalized for asthma.

(ii) In this *Example 3*, Employer *S*'s plan may exclude payment for the hospital stay and the physician services associated with this illness because the care is related to a medical condition for which treatment was received by *B* during the 6-month period before the enrollment date.

Example 4. (i) Individual *D*, who is subject to a preexisting condition exclusion imposed by Employer *U*'s plan, has diabetes, as well as a foot condition caused by poor circulation and retinal degeneration (both of which are conditions that may be directly attributed to diabetes). After enrolling in the plan, *D* stumbles and breaks a leg.

(ii) In this *Example 4*, the leg fracture is not a condition related to *D*'s diabetes, even though poor circulation in *D*'s extremities and poor vision may have contributed towards the accident. However, any additional medical services that may be needed because of *D*'s preexisting diabetic condition that would not be needed by another patient with a broken leg who does not have diabetes may be subject to the preexisting condition exclusion imposed under Employer *U*'s plan.

(ii) *Maximum length of preexisting condition exclusion (the look-forward rule).* A preexisting condition exclusion is not permitted to extend for more than 12 months (18 months in the case of a late enrollee) after the enrollment date. For purposes of this paragraph (a)(1)(ii), the 12-month and 18-month periods after the enrollment date are determined by reference to the anniversary of the enrollment date. For example, for an enrollment date of August 1, 1998, the 12-month period after the enrollment date is the period commencing on August 1, 1998 and continuing through July 31, 1999.

(iii) *Reducing a preexisting condition exclusion period by creditable coverage.* The period of any preexisting condition exclusion that would otherwise apply to an individual under a group health plan is reduced by the number of days of creditable coverage the individual has as of the enrollment date, as counted under §54.9801–4T. For purposes of §54.9801–1T through §54.9801–6T, the phrase ''days of creditable coverage'' has the same meaning as the phrase ''aggregate of the periods of creditable coverage'' as such phrase is used in section 9801(a)(3) of the Internal Revenue Code.

(iv) *Other standards.* See §54.9802–1T for other standards that may apply with respect to certain benefit limitations or restrictions under a group health plan.

(2) *Enrollment definitions*—(i) *Enrollment date* means the first day of coverage or, if there is a waiting period, the first day of the waiting period.

(ii)(A) *First day of coverage* means, in the case of an individual covered for benefits under a group health plan in the group market, the first day of coverage under the plan and, in the case of an individual covered by health insurance coverage in the individual market, the first day of coverage under the policy.

(B) The following example illustrates the rule of paragraph (a)(2)(ii)(A) of this section:

Example. (i) Employer *V*'s group health plan provides for coverage to begin on the first day of the first payroll period following the date an employee is hired and completes the applicable enrollment forms, or on any subsequent January 1 after completion of the applicable enrollment forms. Employer *V*'s plan imposes a preexisting condition exclusion for 12 months (reduced by the individual's creditable coverage) following an individual's enrollment date. Employee *E* is hired by Employer *V* on October 13, 1998 and then on October 14, 1998 completes and files all the forms necessary to enroll in the plan. *E*'s coverage under the plan becomes effective on October 25, 1998 (which is the beginning of the first payroll period after *E*'s date of hire).

(ii) In this *Example*, *E*'s enrollment date is October 13, 1998 (which is the first day of the waiting period for *E*'s enrollment and is also *E*'s date of hire). Accordingly, with respect to *E*, the 6-month period in paragraph (a)(1)(i) would be the period from April 13, 1998 through October 12, 1998, the maximum permissible period during which Employer *V*'s plan could apply a preexisting condition exclusion under paragraph (a)(1)(ii) would be the period from October 13, 1998 through October 12, 1999, and this period would be reduced under paragraph (a)(1)(iii) by *E*'s days of creditable coverage as of October 13, 1998.

(iii) *Late enrollee* means an individual whose enrollment in a plan is a late enrollment.

(iv) (A) *Late enrollment* means enrollment under a group health plan other than on—

(*1*) The earliest date on which coverage can become effective under the terms of the plan; or

(*2*) A special enrollment date for the individual.

(B) If an individual ceases to be eligible for coverage under the plan by terminating employment, and then subsequently becomes eligible for coverage under the plan by resuming employment, only eligibility during the individual's most recent period of employment is taken into account in determining whether the individual is a late enrollee under the plan with respect to the most recent period of coverage. Similar rules apply if an individual again becomes eligible for coverage following a suspension of coverage that applied generally under the plan.

(v) *Examples.* The rules of this paragraph (a)(2) are illustrated by the following examples:

Example 1. (i) Employee *F* first becomes eligible to be covered by Employer *W*'s group health plan on January 1, 1999, but elects not to enroll in the plan until April 1, 1999. April 1, 1999 is not a special enrollment date for *F*.

(ii) In this *Example 1*, *F* would be a late enrollee with respect to *F*'s coverage that became effective under the plan on April 1, 1999.

Example 2. (i) Same as *Example 1*, except that *F* does not enroll in the plan on April 1, 1999 and terminates employment with Employer *W* on July 1, 1999, without having had any health insurance coverage under the plan. *F* is rehired by Employer *W* on January 1, 2000 and is eligible for and elects coverage under Employer *W*'s plan effective on January 1, 2000.

(ii) In this *Example 2*, *F* would not be a late enrollee with respect to *F*'s coverage that became effective on January 1, 2000.

(b) *Exceptions pertaining to preexisting condition exclusions*—(1) *Newborns*—(i) *In general.* Subject to paragraph (b)(3) of this section, a group health plan may not impose any preexisting condition exclusion with regard to a child who, as of the last day of the 30-day period beginning with the date of birth, is covered under any creditable coverage. Accordingly, if a newborn is enrolled in a group health plan (or other creditable coverage) within 30 days after birth and subsequently enrolls in another group health plan without a significant break in coverage, the other plan may not impose any preexisting condition exclusion with regard to the child.

(ii) *Example.* The rule of this paragraph (b)(1) is illustrated by the following example:

Example. (i) Seven months after enrollment in Employer *W*'s group health plan, Individual *E* has a child born with a birth defect. Because the child is enrolled in Employer *W*'s plan within 30 days of birth, no preexisting condition exclusion may be imposed with respect to the child under Employer *W*'s plan. Three months after the child's birth, *E* commences employment with Employer *X* and enrolls with the child in Employer *X*'s plan 45 days after leaving Employer *W*'s plan. Employer *X*'s plan imposes a 12-month exclusion for any preexisting condition.

(ii) In this *Example*, Employer *X*'s plan may not impose any preexisting condition exclusion with respect to *E*'s child because the child was covered within 30 days of birth and had no significant break in coverage. This result applies regardless of whether *E*'s child is included in the certificate of creditable coverage provided to *E* by Employer *W* indicating 300 days of dependent coverage or receives a separate certificate indicating 90 days of coverage. Employer *X*'s plan may impose a preexisting condition exclusion with respect to *E* for up to 65 days for any preexisting condition of *E* for which medical advice, diagnosis, care, or treatment was recommended or received by *E* within the 6-month period ending on *E*'s enrollment date in Employer *X*'s plan.

(2) *Adopted children.* Subject to paragraph (b)(3) of this section, a group health plan may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. This rule does not apply to coverage before the date of such adoption or placement for adoption.

(3) *Break in coverage.* Paragraphs (b)(1) and (2) of this section no longer apply to a child after a significant break in coverage.

(4) *Pregnancy.* A group health plan may not impose a preexisting condition exclusion relating to pregnancy as a preexisting condition.

(5) *Special enrollment dates.* For special enrollment dates relating to new dependents, see § 54.9801–6T(b).

(c) *Notice of plan's preexisting condition exclusion.* A group health plan may not impose a preexisting condition exclusion with respect to a participant or dependent of the participant before notifying the participant, in writing, of

the existence and terms of any preexisting condition exclusion under the plan and of the rights of individuals to demonstrate creditable coverage (and any applicable waiting periods) as required by § 54.9801–5T. The description of the rights of individuals to demonstrate creditable coverage includes a description of the right of the individual to request a certificate from a prior plan or issuer, if necessary, and a statement that the current plan or issuer will assist in obtaining a certificate from any prior plan or issuer, if necessary.

[T.D. 8716, 62 FR 16929, Apr. 8, 1997; 62 FR 31691, June 10, 1997]

§ 54.9801–4T Rules relating to creditable coverage (temporary).

(a) *General rules*—(1) *Creditable coverage.* For purposes of this section, except as provided in paragraph (a)(2) of this section, the term *creditable coverage* means coverage of an individual under any of the following:

(i) A group health plan as defined in § 54.9801–2T.

(ii) Health insurance coverage as defined in § 54.9801–2T (whether or not the entity offering the coverage is subject to Chapter 100 of Subtitle K, and without regard to whether the coverage is offered in the group market, the individual market, or otherwise).

(iii) Part A or B of Title XVIII of the Social Security Act (Medicare).

(iv) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines).

(v) Title 10 U.S.C. Chapter 55 (medical and dental care for members and certain former members of the uniformed services, and for their dependents; for purposes of Title 10 U.S.C. Chapter 55, *uniformed services* means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service).

(vi) A medical care program of the Indian Health Service or of a tribal organization.

(vii) A State health benefits risk pool. For purposes of this section, a State health benefits risk pool means—

(A) An organization qualifying under section 501(c)(26);

(B) A qualified high risk pool described in section 2744(c)(2) of the PHSA; or

(C) Any other arrangement sponsored by a State, the membership composition of which is specified by the State and which is established and maintained primarily to provide health insurance coverage for individuals who are residents of such State and who, by reason of the existence or history of a medical condition—

(*1*) Are unable to acquire medical care coverage for such condition through insurance or from an HMO; or

(*2*) Are able to acquire such coverage only at a rate which is substantially in excess of the rate for such coverage through the membership organization.

(viii) A health plan offered under Title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefits Program).

(ix) A public health plan. For purposes of this section, a public health plan means any plan established or maintained by a State, county, or other political subdivision of a State that provides health insurance coverage to individuals who are enrolled in the plan.

(x) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

(2) *Excluded coverage.* Creditable coverage does not include coverage consisting solely of coverage of excepted benefits (described in § 54.9831–1T).

(3) *Methods of counting creditable coverage.* For purposes of reducing any preexisting condition exclusion period, as provided under § 54.9801–3T(a)(1)(iii), a group health plan determines the amount of an individual's creditable coverage by using the standard method described in paragraph (b) of this section, except that the plan may use the alternative method under paragraph (c) of this section with respect to any or all of the categories of benefits described under paragraph (c)(3) of this section or may provide that a health insurance issuer offering health insurance coverage under the plan may use the alternative method of counting creditable coverage.

(b) *Standard method*—(1) *Specific benefits not considered.* Under the standard

method, a group health plan determines the amount of creditable coverage without regard to the specific benefits included in the coverage.

(2) *Counting creditable coverage*—(i) *Based on days.* For purposes of reducing the preexisting condition exclusion period, a group health plan determines the amount of creditable coverage by counting all the days that the individual has under one or more types of creditable coverage. Accordingly, if on a particular day, an individual has creditable coverage from more than one source, all the creditable coverage on that day is counted as one day. Further, any days in a waiting period for a plan or policy are not creditable coverage under the plan or policy.

(ii) *Days not counted before significant break in coverage.* Days of creditable coverage that occur before a significant break in coverage are not required to be counted.

(iii) *Definition of significant break in coverage.* A significant break in coverage means a period of 63 consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage. (See section 731(b)(2)(iii) of ERISA and section 2723(b)(2)(iii) of the PHSA which exclude from preemption State insurance laws that require a break of more than 63 days before an individual has a significant break in coverage for purposes of State law.)

(iv) *Examples.* The following examples illustrate how creditable coverage is counted in reducing preexisting condition exclusion periods under this paragraph (b)(2):

Example 1. (i) Individual *A* works for Employer *P* and has creditable coverage under Employer *P*'s plan for 18 months before *A*'s employment terminates. *A* is hired by Employer *Q*, and enrolls in Employer *Q*'s group health plan, 64 days after the last date of coverage under Employer *P*'s plan. Employer *Q*'s plan has a 12-month preexisting condition exclusion period.

(ii) In this *Example 1,* because *A* had a break in coverage of 63 days, Employer *Q*'s plan may disregard *A*'s prior coverage and *A* may be subject to a 12-month preexisting condition exclusion period.

Example 2. (i) Same facts as *Example 1*, except that *A* is hired by Employer *Q*, and enrolls in Employer *Q*'s plan, on the 63rd day after the last date of coverage under Employer *P*'s plan.

(ii) In this *Example 2*, *A* has a break in coverage of 62 days. Because *A*'s break in coverage is not a significant break in coverage, Employer *Q*'s plan must count *A*'s prior creditable coverage for purposes of reducing the plan's preexisting condition exclusion as it applies to *A*.

Example 3. (i) Same facts as *Example 1*, except that Employer *Q*'s plan provides benefits through an insurance policy that, as required by applicable State insurance laws, defines a significant break in coverage as 90 days.

(ii) In this *Example 3*, the issuer that provides group health insurance to Employer *Q*'s plan must count *A*'s period of creditable coverage prior to the 63-day break.

Example 4. (i) Same facts as *Example 3*, except that Employer *Q*'s plan is a self-insured plan, and, thus is not subject to State insurance laws.

(ii) In this *Example 4*, the plan is not governed by the longer break rules under State insurance law and *A*'s previous coverage may be disregarded.

Example 5. (i) Individual *B* begins employment with Employer *R* 45 days after terminating coverage under a prior group health plan. Employer *R*'s plan has a 30-day waiting period before coverage begins. *B* enrolls in Employer *R*'s plan when first eligible.

(ii) In this *Example 5*, *B* does not have a significant break in coverage for purposes of determining whether *B*'s prior coverage must be counted by Employer *R*'s plan. *B* has only a 44-day break in coverage because the 30-day waiting period is not taken into account in determining a significant break in coverage.

Example 6. (i) Individual *C* works for Employer *S* and has creditable coverage under Employer *S*'s plan for 200 days before *C*'s employment is terminated and coverage ceases. *C* is then unemployed and does not have any creditable coverage for 51 days before being hired by Employer *T*. Employer *T*'s plan has a 3-month waiting period. *C* works for Employer *T* for 2 months and then terminates employment. Eleven days after terminating employment with Employer *T*, *C* begins working for Employer *U*. Employer *U*'s plan has no waiting period, but has a 6-month preexisting condition exclusion period.

(ii) In this *Example 6*, *C* does not have a significant break in coverage because, after disregarding the waiting period under Employer *T*'s plan, *C* had only a 62-day break in coverage (51 days plus 11 days). Accordingly, *C* has 200 days of creditable coverage and Employer *U*'s plan may not apply its 6-month preexisting condition exclusion period with respect to *C*.

Example 7. (i) Individual *D* terminates employment with Employer *V* on January 13, 1998 after being covered for 24 months under Employer *V*'s group health plan. On March 17, the 63rd day without coverage, *D* applies for a health insurance policy in the individual market. *D*'s application is accepted and the coverage is made effective May 1.

(ii) In this *Example 7*, because *D* applied for the policy before the end of the 63rd day, and coverage under the policy ultimately became effective, the period between the date of application and the first day of coverage is a waiting period and no significant break in coverage occurred even though the actual period without coverage was 107 days.

Example 8. (i) Same facts as *Example 7*, except that *D*'s application for a policy in the individual market is denied.

(ii) In this *Example 8*, because *D* did not obtain coverage following application, *D* incurred a significant break in coverage on the 64th day.

(v) *Other permissible counting methods*—(*A*) *Rule.* Notwithstanding any other provision of this paragraph (b)(2), for purposes of reducing a preexisting condition exclusion period (but not for purposes of issuing a certificate under § 54.9801–5T), a group health plan may determine the amount of creditable coverage in any other manner that is at least as favorable to the individual as the method set forth in this paragraph (b)(2), subject to the requirements of other applicable law.

(B) *Example.* The rule of this paragraph (b)(2)(v) is illustrated by the following example:

Example. (i) Individual *F* has coverage under Group Health Plan *Y* from January 3, 1997 through March 25, 1997. *F* then becomes covered by Group Health Plan *Z*. *F*'s enrollment date in Plan *Z* is May 1, 1997. Plan *Z* has a 12-month preexisting condition exclusion period.

(ii) In this *Example*, Plan *Z* may determine, in accordance with the rules prescribed in paragraph (b)(2) (i), (ii), and (iii), that *F* has 82 days of creditable coverage (29 days in January, 28 days in February, and 25 days in March). Thus, the preexisting condition exclusion period will no longer apply to *F* on February 8, 1998 (82 days before the 12-month anniversary of *F*'s enrollment (May 1)), For administrative convenience, however, Plan *Z* may consider that the preexisting condition exclusion period will no longer apply to *F* on the first day of the month (February 1).

(c) *Alternative method—(1) Specific benefits considered.* Under the alternative method, a group health plan determines the amount of creditable coverage based on coverage within any category of benefits described in paragraph (c)(3) of this section and not based on coverage for any other benefits. The plan may use the alternative method for any or all the categories. The plan may apply a different preexisting condition exclusion period with respect to each category (and may apply a different preexisting condition exclusion period for benefits that are not within any category). The creditable coverage determined for a category of benefits applies only for purposes of reducing the preexisting condition exclusion period with respect to that category. An individual's creditable coverage for benefits that are not within any category for which the alternative method is being used is determined under the standard method of paragraph (b) of this section.

(2) *Uniform application.* A plan using the alternative method is required to apply it uniformly to all participants and beneficiaries under the plan. A plan that provides benefits through one or more insurance policies (or in part through one or more insurance policies) will not fail the uniform application requirement of this paragraph (c)(2) if the alternative method is used (or not used) separately with respect to participants and beneficiaries under any policy, provided that the alternative method is applied uniformly with respect to all coverage under that policy. The use of the alternative method is required to be set forth in the plan.

(3) *Categories of benefits.* The alternative method for counting creditable coverage may be used for coverage for the following categories of benefits—

(i) Mental health;

(ii) Substance abuse treatment;

(iii) Prescription drugs;

(iv) Dental care; or

(v) Vision care.

(4) *Plan notice.* If the alternative method is used, the plan is required to—

(i) State prominently that the plan is using the alternative method of counting creditable coverage in disclosure statements concerning the plan, and state this to each enrollee at the time of enrollment under the plan; and

(ii) Include in these statements a description of the effect of using the alternative method, including an identification of the categories used.

(5) *Disclosure of information on previous benefits.* See § 54.9801–5T(b) for special rules concerning disclosure of coverage to a plan (or issuer) using the alternative method of counting creditable coverage under this paragraph (c).

(6) *Counting creditable coverage*—(i) *In general.* Under the alternative method, the group health plan counts creditable coverage within a category if any level of benefits is provided within the category. Coverage under a reimbursement account or arrangement such as a flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code) does not constitute coverage within any category.

(ii) *Special rules.* In counting an individual's creditable coverage under the alternative method, the group health plan first determines the amount of the individual's creditable coverage that may be counted under paragraph (b) of this section, up to a total of 365 days of the most recent creditable coverage (546 days for a late enrollee). The period over which this creditable coverage is determined is referred to as the determination period. Then, for the category specified under the alternative method, the plan counts within the category all days of coverage that occurred during the determination period (whether or not a significant break in coverage for that category occurs), and reduces the individual's preexisting condition exclusion period for that category by that number of days. The plan may determine the amount of creditable coverage in any other reasonable manner, uniformly applied, this is at least as favorable to the individual.

(iii) *Example.* The rules of this paragraph (c)(6) are illustrated by the following example:

Example. (i) Individual *D* enrolls in Employer *V*'s plan on January 1, 2001. Coverage under the plan includes prescription drug benefits. On April 1, 2001, the plan ceases providing prescription drug benefits. *D*'s employment with Employer *V* ends on January 1, 2002, after *D* was covered under Employer *V*'s group health plan for 365 days. *D* enrolls in Employer *Y*'s plan on February 1, 2002 (*D*'s enrollment date). Employer *Y*'s plan uses the alternative method of counting creditable coverage and imposes a 12-month preexisting condition exclusion on prescription drug benefits.

(ii) In this *Example,* Employer *Y*'s plan may impose a 275-day preexisting condition exclusion with respect to *D* for prescription drug benefits because *D* had 90 days of creditable coverage relating to prescription drug benefits within *D*'s determination period.

[T.D. 8716, 62 FR 16930, Apr. 8, 1997; 62 FR 31669, 31691, June 10, 1997, as amended by T.D. 8741, 62 FR 66952, Dec. 22, 1997]

§ 54.9801–5T Certification and disclosure of previous coverage (temporary).

(a) *Certificate of creditable coverage*—(1) *Entities required to provide certificate*—(i) *In general.* A group health plan is required to furnish certificates of creditable coverage in accordance with this paragraph (a). (See PHSA section 2701(e) and ERISA section 701(e) under which this obligation is also imposed on a health insurance issuer offering group health insurance coverage.)

(ii) *Duplicate certificates not required.* An entity required to provide a certificate under this paragraph (a)(1) for an individual is deemed to have satisfied the certification requirements for that individual if another party provides the certificate, but only to the extent that information relating to the individual's creditable coverage and waiting or affiliation period is provided by the other party. For example, a group health plan is deemed to have satisfied the certification requirement with respect to a participant or beneficiary if any other entity actually provides a certificate that includes the information required under paragraph (a)(3) of this section with respect to the participant or beneficiary.

(iii) *Special rule for group health plans.* To the extent coverage under a plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirements under this paragraph (a)(1) if any issuer offering the coverage is required to provide the certificates pursuant to an agreement between the plan and the issuer. For example, if there is an agreement between an issuer and the employer sponsoring the plan under

which the issuer agrees to provide certificates for individuals covered under the plan, and the issuer fails to provide a certificate to an individual when the plan would have been required to provide one under this paragraph (a), then the plan does not violate the certification requirements of this paragraph (a) (though the issuer would have violated the certification requirements pursuant to section 2701(e) of the PHSA and section 701(e) of ERISA).

(iv) *Special rules relating to issuers providing coverage under a plan*—(A)(*1*) *Responsibility of issuer for coverage period.* See 29 CFR 2590.701–5 and 45 CFR 146.115, under which an issuer is not required to provide information regarding coverage provided to an individual by another party.

(*2*) *Example.* The rule referenced by this paragraph (a)(1)(iv)(A) is illustrated by the following example:

Example. (i) A plan offers coverage with an HMO option from one issuer and an indemnity option from a different issuer. The HMO has not entered into an agreement with the plan to provide certificates as permitted under paragraph (a)(1)(iii) of this section.

(ii) In this *Example,* if an employee switches from the indemnity option to the HMO option and later ceases to be covered under the plan, any certificate provided by the HMO is not required to provide information regarding the employee's coverage under the indemnity option.

(B) (*1*) *Cessation of issuer coverage prior to cessation of coverage under a plan.* If an individual's coverage under an issuer's policy ceases before the individual's coverage under the plan ceases, the issuer is required (under section 2701(e) of the PHSA and section 701(e) of ERISA) to provide sufficient information to the plan (or to another party designated by the plan) to enable a certificate to be provided by the plan (or other party), after cessation of the individual's coverage under the plan, that reflects the period of coverage under the policy. The provision of that information to the plan will satisfy the issuer's obligation to provide an automatic certificate for that period of creditable coverage for the individual under paragraph (a)(2)(ii) and (3) of this section. In addition, an issuer providing that information is required to cooperate with the plan in responding to any request made under paragraph (b)(1) of this section (relating to the alternative method of counting creditable coverage). If the individual's coverage under the plan ceases at the time the individual's coverage under the issuer's policy ceases, the issuer must provide an automatic certificate under paragraph (a)(2)(ii) of this section. An issuer may presume that an individual whose coverage ceases at a time other than the effective date for changing enrollment options has ceased to be covered under the plan.

(*2*) *Example.* The rule of this paragraph (a)(1)(iv)(B) is illustrated by the following example:

Example. (i) A group health plan provides coverage under an HMO option and an indemnity option with a different issuer, and only allows employees to switch on each January 1. Neither the HMO nor the indemnity issuer has entered into an agreement with the plan to provide certificates as permitted under paragraph (a)(1)(iii) of this section.

(ii) In this *Example,* if an employee switches from the indemnity option to the HMO option on January 1, the issuer must provide the plan (or a person designated by the plan) with appropriate information with respect to the individual's coverage with the indemnity issuer. However, if the individual's coverage with the indemnity issuer ceases at a date other than January 1, the issuer is instead required to provide the individual with an automatic certificate.

(2) *Individuals for whom certificate must be provided; timing of issuance*—(i) *Individuals.* A certificate must be provided, without charge, for participants or dependents who are or were covered under a group health plan upon the occurrence of any of the events described in paragraph (a)(2)(ii) or (iii) of this section.

(ii) *Issuance of automatic certificates.* The certificates described in this paragraph (a)(2)(ii) are referred to as automatic certificates.

(A) *Qualified beneficiaries upon a qualifying event.* In the case of an individual who is a qualified beneficiary (as defined in section 4980B(g)(1)) entitled to elect COBRA continuation coverage, an automatic certificate is required to be provided at the time the individual would lose coverage under

the plan in the absence of COBRA continuation coverage or alternative coverage elected instead of COBRA continuation coverage. A plan satisfies this requirement if it provides the automatic certificate no later than the time a notice is required to be furnished for a qualifying event under section 4980B(f)(6) (relating to notices required under COBRA).

(B) *Other individuals when coverage ceases.* In the case of an individual who is not a qualified beneficiary entitled to elect COBRA continuation coverage, an automatic certificate is required to be provided at the time the individual ceases to be covered under the plan. A plan satisfies this requirement if it provides the automatic certificate within a reasonable time period thereafter. In the case of an individual who is entitled to elect to continue coverage under a State program similar to COBRA and who receives the automatic certificate not later than the time a notice is required to be furnished under the State program, the certificate is deemed to be provided within a reasonable time period after the cessation of coverage under the plan.

(C) *Qualified beneficiaries when COBRA ceases.* In the case of an individual who is a qualified beneficiary and has elected COBRA continuation coverage (or whose coverage has continued after the individual became entitled to elect COBRA continuation coverage), an automatic certificate is to be provided at the time the individual's coverage under the plan ceases. A plan satisfies this requirement if it provides the automatic certificate within a reasonable time after coverage ceases (or after the expiration of any grace period for nonpayment of premiums). An automatic certificate is required to be provided to such an individual regardless of whether the individual has previously received an automatic certificate under paragraph (a)(2)(ii)(A) of this section.

(iii) *Any individual upon request.* Requests for certificates are permitted to be made by, or on behalf of, an individual within 24 months after coverage ceases. Thus, for example, a plan in which an individual enrolls may, if authorized by the individual, request a certificate of the individual's creditable coverage on behalf of the individual from a plan in which the individual was formerly enrolled. After the request is received, a plan or issuer is required to provide the certificate by the earliest date that the plan, acting in a reasonable and prompt fashion, can provide the certificate. A certificate is required to be provided under this paragraph (a)(2)(iii) even if the individual has previously received an automatic certificate under paragraph (a)(2)(ii) of this section.

(iv) *Examples.* The following examples illustrate the rules of this paragraph (a)(2):

Example 1. (i) Individual *A* terminates employment with Employer *Q*. *A* is a qualified beneficiary entitled to elect COBRA continuation coverage under Employer *Q*'s group health plan. A notice of the rights provided under COBRA is typically furnished to qualified beneficiaries under the plan within 10 days after a covered employee terminates employment.

(ii) In this *Example 1*, the automatic certificate may be provided at the same time that *A* is provided the COBRA notice.

Example 2. (i) Same facts as *Example 1*, except that the automatic certificate for *A* is not completed by the time the COBRA notice is furnished to *A*.

(ii) In this *Example 2*, the automatic certificate may be provided within the period permitted by law for the delivery of notices under COBRA.

Example 3. (i) Employer *R* maintains an insured group health plan. *R* has never had 20 employees and thus *R*'s plan is not subject to the COBRA continuation coverage provisions. However, *R* is in a State that has a State program similar to COBRA. *B* terminates employment with *R* and loses coverage under *R*'s plan.

(ii) In this *Example 3*, the automatic certificate may be provided not later than the time a notice is required to be furnished under the State program.

Example 4. (i) Individual *C* terminates employment with Employer *S* and receives both a notice of *C*'s rights under COBRA and an automatic certificate. *C* elects COBRA continuation coverage under Employer *S*'s group health plan. After four months of COBRA continuation coverage and the expiration of a 30-day grace period, Employer *S*'s group health plan determines that *C*'s COBRA continuation coverage has ceased due to failure to make a timely payment for continuation coverage.

(ii) In this *Example 4*, the plan must provide an updated automatic certificate to *C*

within a reasonable time after the end of the grace period.

Example 5. (i) Individual *D* is currently covered under the group health plan of Employer *T*. *D* requests a certificate, as permitted under paragraph (a)(2)(iii) of this section. Under the procedure for Employer *T*'s plan, certificates are mailed (by first class mail) 7 business days following receipt of the request. This date reflects the earliest date that the plan, acting in a reasonable and prompt fashion, can provide certificates.

(ii) In this *Example 5*, the plan's procedure satisfies paragraph (a)(2)(iii) of this section.

(3) *Form and content of certificate*—(i) *Written certificate*—(A) *In general.* Except as provided in paragraph (a)(3)(i)(B) of this section, the certificate must be provided in writing (including any form approved by the Secretary as a writing).

(B) *Other permissible forms.* No written certificate is required to be provided under paragraph (a) with respect to a particular event described in paragraph (a)(2) (ii) or (iii) of this section if——

(*1*) An individual is entitled to receive a certificate;

(*2*) The individual requests that the certificate be sent to another plan or issuer instead of to the individual;

(*3*) The plan or issuer that would otherwise receive the certificate agrees to accept the information in this paragraph (a)(3) through means other than a written certificate (e.g., by telephone); and

(*4*) The receiving plan or issuer receives such information from the sending plan or issuer in such form within the time periods required under paragraph (a)(2) of this section.

(ii) *Required information.* The certificate must include the following——

(A) The date the certificate is issued;

(B) The name of the group health plan that provided the coverage described in the certificate;

(C) The name of the participant or dependent with respect to whom the certificate applies, and any other information necessary for the plan providing the coverage specified in the certificate to identify the individual, such as the individual's identification number under the plan and the name of the participant if the certificate is for (or includes) a dependent;

(D) The name, address, and telephone number of the plan administrator or issuer required to provide the certificate;

(E) The telephone number to call for further information regarding the certificate (if different from paragraph (a)(3)(ii)(D) of this section);

(F) Either—

(*1*) A statement that an individual has at least 18 months (for this purpose, 546 days is deemed to be 18 months) of creditable coverage, disregarding days of creditable coverage before a significant break in coverage, or

(*2*) The date any waiting period (and affiliation period, if applicable) began and the date creditable coverage began; and

(G) The date creditable coverage ended, unless the certificate indicates that creditable coverage is continuing as of the date of the certificate.

(iii) *Periods of coverage under certificate.* If an automatic certificate is provided pursuant to paragraph (a)(2)(ii) of this section, the period that must be included on the certificate is the last period of continuous coverage ending on the date coverage ceased. If an individual requests a certificate pursuant to paragraph (a)(2)(iii) of this section, a certificate must be provided for each period of continuous coverage ending within the 24-month period ending on the date of the request (or continuing on the date of the request). A separate certificate may be provided for each such period of continuous coverage.

(iv) *Combining information for families.* A certificate may provide information with respect to both a participant and the participant's dependents if the information is identical for each individual or, if the information is not identical, certificates may be provided on one form if the form provides all the required information for each individual and separately states the information that is not identical.

(v) *Model certificate.* The requirements of paragraph (a)(3)(ii) of this section are satisfied if the plan provides a certificate in accordance with a model certificate authorized by the Secretary.

(vi) *Excepted benefits; categories of benefits.* No certificate is required to be

furnished with respect to excepted benefits described in § 54.9831–1T. In addition, the information in the certificate regarding coverage is not required to specify categories of benefits described in § 54.9801–4T(c) (relating to the alternative method of counting creditable coverage). However, if excepted benefits are provided concurrently with other creditable coverage (so that the coverage does not consist solely of excepted benefits), information concerning the benefits may be required to be disclosed under paragraph (b) of this section.

(4) *Procedures*—(i) *Method of delivery.* The certificate is required to be provided to each individual described in paragraph (a)(2) of this section or an entity requesting the certificate on behalf of the individual. The certificate may be provided by first-class mail. If the certificate or certificates are provided to the participant and the participant's spouse at the participant's last known address, then the requirements of this paragraph (a)(4) are satisfied with respect to all individuals residing at that address. If a dependent's last known address is different than the participant's last known address, a separate certificate is required to be provided to the dependent at the dependent's last known address. If separate certificates are being provided by mail to individuals who reside at the same address, separate mailings of each certificate are not required.

(ii) *Procedure for requesting certificates.* A plan or issuer must establish a procedure for individuals to request and receive certificates pursuant to paragraph (a)(2)(iii) of this section.

(iii) *Designated recipients.* If an automatic certificate is required to be provided under paragraph (a)(2)(ii) of this section, and the individual entitled to receive the certificate designates another individual or entity to receive the certificate, the plan or issuer responsible for providing the certificate is permitted to provide the certificate to the designated party. If a certificate is required to be provided upon request under paragraph (a)(2)(iii) of this section and the individual entitled to receive the certificate designates another individual or entity to receive the certificate, the plan or issuer responsible for providing the certificate is required to provide the certificate to the designated party.

(5) *Special rules concerning dependent coverage*—(i)(A) *Reasonable efforts.* A plan is required to use reasonable efforts to determine any information needed for a certificate relating to dependent coverage. In any case in which an automatic certificate is required to be furnished with respect to a dependent under paragraph (a)(2)(ii) of this section, no individual certificate is required to be furnished until the plan knows (or making reasonable efforts should know) of the dependent's cessation of coverage under the plan.

(B) *Example.* The rules of this paragraph (a)(5) are illustrated by the following example:

Example. (i) A group health plan covers employees and their dependents. The plan annually requests all employees to provide updated information regarding dependents, including the specific date on which an employee has a new dependent or on which a person ceases to be a dependent of the employee.

(ii) In this *Example,* the plan has satisfied the standard in this paragraph (a)(5)(i) that it make reasonable efforts to determine the cessation of dependents' coverage and the related dependent coverage information.

(ii) *Special rules for demonstrating coverage.* If a certificate furnished by a plan or issuer does not provide the name of any dependent of an individual covered by the certificate, the individual may, if necessary, use the procedures described in paragraph (c)(4) of this section for demonstrating dependent status. In addition, an individual may, if necessary, use these procedures to demonstrate that a child was enrolled within 30 days of birth, adoption, or placement for adoption. See § 54.9801–3T(b), under which such a child would not be subject to a preexisting condition exclusion.

(iii) *Transition rule for dependent coverage through June 30, 1998*—(A) *In general.* A group health plan that cannot provide the names of dependents (or related coverage information) for purposes of providing a certificate of coverage for a dependent may satisfy the requirements of paragraph (a)(3)(ii)(C) of this section by providing the name of the participant covered by the group health plan and specifying that the

type of coverage described in the certificate is for dependent coverage (e.g., family coverage or employee-plus-spouse coverage).

(B) *Certificates provided on request.* For purposes of certificates provided on the request of, or on behalf of, an individual pursuant to paragraph (a)(2)(iii) of this section, a plan must make reasonable efforts to obtain and provide the names of any dependent covered by the certificate where such information is requested to be provided. If a certificate does not include the name of any dependent of an individual covered by the certificate, the individual may, if necessary, use the procedures described in paragraph (c) of this section for submitting documentation to establish that the creditable coverage in the certificate applies to the dependent.

(C) *Demonstrating a dependent's creditable coverage.* See paragraph (c)(4) of this section for special rules to demonstrate dependent status.

(D) *Duration.* This paragraph (a)(5)(iii) is only effective for certifications provided with respect to events occurring through June 30, 1998.

(6) *Special certification rules for entities not subject to Chapter 100 of Subtitle K of the Internal Revenue Code*—(i) *Issuers.* For rules requiring that issuers in the group and individual markets provide certificates consistent with the rules in this section, see section 701(e) of ERISA and sections 2701(e), 2721(b)(1)(B), and 2743 of the PHSA.

(ii) *Other entities.* For special rules requiring that certain other entities, not subject to Chapter 100 of Subtitle K of the Internal Revenue Code, provide certificates consistent with the rules in the section, see section 2791(a)(3) of the PHSA applicable to entities described in sections 2701(c)(1) (C), (D), (E), and (F) (relating to Medicare, Medicaid, CHAMPUS, and Indian Health Service), section 2721(b)(1)(A) of the PHSA applicable to nonfederal governmental plans generally, and section 2721(b)(2)(C)(ii) of the PHSA applicable to nonfederal governmental plans that elect to be excluded from the requirements of Subparts 1 through 3 of Part A of Title XXVII of the PHSA.

(b) *Disclosure of coverage to a plan, or issuer, using the alternative method of counting creditable coverage*—(1) *In general.* If an individual enrolls in a group health plan with respect to which the plan (or issuer) uses the alternative method of counting creditable coverage described in §54.9801–4T(c), the individual provides a certificate of coverage under paragraph (a) of this section, and the plan (or issuer) in which the individual enrolls so requests, the entity that issued the certificate (the prior entity) is required to disclose promptly to a requesting plan (or issuer) (the requesting entity) the information set forth in paragraph (b)(2) of this section.

(2) *Information to be disclosed.* The prior entity is required to identify to the requesting entity the categories of benefits with respect to which the requesting entity is using the alternative method of counting creditable coverage, and the requesting entity may identify specific information that the requesting entity reasonably needs in order to determine the individual's creditable coverage with respect to any such category. The prior entity is required to disclose promptly to the requesting entity the creditable coverage information so requested.

(3) *Charge for providing information.* The prior entity furnishing the information under paragraph (b) of this section may charge the requesting entity for the reasonable cost of disclosing such information.

(c) *Ability of an individual to demonstrate creditable coverage and waiting period information*—(1) *In general.* The rules in this paragraph (c) implement section 9801(c)(4), which permits individuals to establish creditable coverage through means other than certificates, and section 9801(e)(3), which requires the Secretary to establish rules designed to prevent an individual's subsequent coverage under a group health plan or health insurance coverage from being adversely affected by an entity's failure to provide a certificate with respect to that individual. If the accuracy of a certificate is contested or a certificate is unavailable when needed by the individual, the individual has the right to demonstrate creditable coverage (and waiting or affiliation periods) through the presentation of documents or other means. For example,

the individual may make such a demonstration when—

(i) An entity has failed to provide a certificate within the required time period;

(ii) The individual has creditable coverage but an entity may not be required to provide a certificate of the coverage pursuant to paragraph (a) of this section;

(iii) The coverage is for a period before July 1, 1996;

(iv) The individual has an urgent medical condition that necessitates a determination before the individual can deliver a certificate to the plan; or

(v) The individual lost a certificate that the individual had previously received and is unable to obtain another certificate.

(2) *Evidence of creditable coverage*—(i) *Consideration of evidence.* A plan is required to take into account all information that it obtains or that is presented on behalf of an individual to make a determination, based on the relevant facts and circumstances, whether an individual has creditable coverage and is entitled to offset all or a portion of any preexisting condition exclusion period. A plan shall treat the individual as having furnished a certificate under paragraph (a) of this section if the individual attests to the period of creditable coverage, the individual also presents relevant corroborating evidence of some creditable coverage during the period, and the individual cooperates with the plan's efforts to verify the individual's coverage. For this purpose, cooperation includes providing (upon the plan's or issuer's request) a written authorization for the plan to request a certificate on behalf of the individual, and cooperating in efforts to determine the validity of the corroborating evidence and the dates of creditable coverage. While a plan may refuse to credit coverage where the individual fails to cooperate with the plan's or issuer's efforts to verify coverage, the plan may not consider an individual's inability to obtain a certificate to be evidence of the absence of creditable coverage.

(ii) *Documents.* Documents that may establish creditable coverage (and waiting periods or affiliation periods) in the absence of a certificate include explanations of benefit claims (EOBs) or other correspondence from a plan or issuer indicating coverage, pay stubs showing a payroll deduction for health coverage, a health insurance identification card, a certificate of coverage under a group health policy, records from medical care providers indicating health coverage, third party statements verifying periods of coverage, and any other relevant documents that evidence periods of health coverage.

(iii) *Other evidence.* Creditable coverage (and waiting period or affiliation period information) may also be established through means other than documentation, such as by a telephone call from the plan or provider to a third party verifying creditable coverage.

(iv) *Example.* The rules of this paragraph (c)(2) are illustrated by the following example:

Example. (i) Individual *F* terminates employment with Employer *W* and, a month later, is hired by Employer *X*. Employer *X*'s group health plan imposes a preexisting condition exclusion of 12 months on new enrollees under the plan and uses the standard method of determining creditable coverage. *F* fails to receive a certificate of prior coverage from the self-insured group health plan maintained by *F*'s prior employer, Employer *W*, and requests a certificate. However, *F* (and Employer's *X*'s plan, on *F*'s behalf) is unable to obtain a certificate from Employer *W*'s plan. *F* attests that, to the best of *F*'s knowledge, *F* had at least 12 months of continuous coverage under Employer *W*'s plan, and that the coverage ended no earlier than *F*'s termination of employment from Employer *W*. In addition, *F* presents evidence of coverage, such as an explanation of benefits for a claim that was made during the relevant period.

(ii) In this *Example*, based solely on these facts, *F* has demonstrated creditable coverage for the 12 months of coverage under Employer *W*'s plan in the same manner as if *F* had presented a written certificate of creditable coverage.

(3) *Demonstrating categories of creditable coverage.* Procedures similar to those described in this paragraph (c) apply in order to determine an individual's creditable coverage with respect to any category under paragraph (b) of this section (relating to determining creditable coverage under the alternative method).

(4) *Demonstrating dependent status.* If, in the course of providing evidence (including a certificate) of creditable coverage, an individual is required to demonstrate dependent status, the group health plan or issuer is required to treat the individual as having furnished a certificate showing the dependent status if the individual attests to such dependency and the period of such status and the individual cooperates with the plan's or issuer's efforts to verify the dependent status.

(d) *Determination and notification of creditable coverage*—(1) *Reasonable time period.* In the event that a group health plan receives information under paragraph (a) of this section (certifications), paragraph (b) of this section (disclosure of information relating to the alternative method), or paragraph (c) of this section (other evidence of creditable coverage), the plan is required, within a reasonable time period following receipt of the information, to make a determination regarding the individual's period of creditable coverage and notify the individual of the determination in accordance with paragraph (d)(2) of this section. Whether a determination and notification regarding an individual's creditable coverage is made within a reasonable time period is determined based on the relevant facts and circumstances. Relevant facts and circumstances include whether a plan's application of a preexisting condition exclusion would prevent an individual from having access to urgent medical services.

(2) *Notification to individual of period of preexisting condition exclusion.* A plan seeking to impose a preexisting condition exclusion is required to disclose to the individual, in writing, its determination of any preexisting condition exclusion period that applies to the individual, and the basis for such determination, including the source and substance of any information on which the plan relied. In addition, the plan is required to provide the individual with a written explanation of any appeal procedures established by the plan, and with a reasonable opportunity to submit additional evidence of creditable coverage. However, nothing in this paragraph (d) or paragraph (c) of this section prevents a plan from modifying an initial determination of creditable coverage if it determines that the individual did not have the claimed creditable coverage, provided that—

(i) A notice of such reconsideration, as described in this paragraph (d), is provided to the individual; and

(ii) Until the final determination is made, the plan, for purposes of approving access to medical services (such as a pre-surgery authorization), acts in a manner consistent with the initial determination.

(3) *Examples.* The following examples illustrate this paragraph (d):

Example 1. (i) Individual *G* is hired by Employer *Y*. Employer *Y*'s group health plan imposes a preexisting condition exclusion for 12 months with respect to new enrollees and uses the standard method of determining creditable coverage. Employer *Y*'s plan determines that *G* is subject to a 4-month preexisting condition exclusion, based on a certificate of creditable coverage that is provided by *G* to Employer *Y*'s plan indicating 8 months of coverage under *G*'s prior group health plan.

(ii) In this *Example 1*, Employer *Y*'s plan must notify *G* within a reasonable period of time following receipt of the certificate that *G* is subject to a 4-month preexisting condition exclusion beginning on *G*'s enrollment date in *Y*'s plan.

Example 2. (i) Same facts as in *Example 1*, except that Employer *Y*'s plan determines that *G* has 14 months of creditable coverage based on *G*'s certificate indicating 14 months of creditable coverage under *G*'s prior plan.

(ii) In this *Example 2*, Employer *Y*'s plan is not required to notify *G* that *G* will not be subject to a preexisting condition exclusion.

Example 3. (i) Individual *H* is hired by Employer *Z*. Employer *Z*'s group health plan imposes a preexisting condition exclusion for 12 months with respect to new enrollees and uses the standard method of determining creditable coverage. *H* develops an urgent health condition before receiving a certificate of prior coverage. *H* attests to the period of prior coverage, presents corroborating documentation of the coverage period, and authorizes the plan to request a certificate on *H*'s behalf.

(ii) In this *Example 3*, Employer *Z*'s plan must review the evidence presented by *H*. In addition, the plan must make a determination and notify *H* regarding any preexisting condition exclusion period that applies to *H* (and the basis of such determination) within a reasonable time period following receipt of

the evidence that is consistent with the urgency of *H*'s health condition. (This determination may be modified as permitted under paragraph (d)(2) of this section.)

[T.D. 8716, 62 FR 16932, Apr. 8, 1997; 62 FR 31669, 31691, June 10, 1997, as amended by T.D. 8741, 62 FR 66952, Dec. 22, 1997]

§ 54.9801–6T Special enrollment periods (temporary).

(a) *Special enrollment for certain individuals who lose coverage*—(1) *In general.* A group health plan is required to permit employees and dependents described in paragraph (a)(2), (3) or (4) of this section to enroll for coverage under the terms of the plan if the conditions in paragraph (a)(5) of this section are satisfied and the enrollment is requested within the period described in paragraph (a)(6) of this section. The enrollment is effective at the time described in paragraph (a)(7) of this section. The special enrollment rights under this paragraph (a) apply without regard to the dates on which an individual would otherwise be able to enroll under the plan. (See PHSA section 2701(f)(1) and ERISA section 701(f)(1) under which this obligation is also imposed on a health insurance issuer offering group health insurance coverage.)

(2) *Special enrollment of an employee only.* An employee is described in this paragraph (a)(2) if the employee is eligible, but not enrolled, for coverage under the terms of the plan and, when enrollment was previously offered to the employee under the plan and was declined by the employee, the employee was covered under another group health plan or had other health insurance coverage.

(3) *Special enrollment of dependents only.* A dependent is described in this paragraph (a)(3) if the dependent is a dependent of an employee participating in the plan, the dependent is eligible, but not enrolled, for coverage under the terms of the plan and when enrollment was previously offered under the plan and was declined, the dependent was covered under another group health plan or had other health insurance coverage.

(4) *Special enrollment of both employee and dependent.* An employee and any dependent of the employee are described in this paragraph (a)(4) if they are eligible, but not enrolled, for coverage under the terms of the plan and, when enrollment was previously offered to the employee or dependent under the plan and was declined, the employee or dependent was covered under another group health plan or had other health insurance coverage.

(5) *Conditions for special enrollment.* An employee or dependent is eligible to enroll during a special enrollment period if each of the following applicable conditions is met:

(i) When the employee declined enrollment for the employee or the dependent, the employee stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment. This paragraph (a)(5)(i) applies only if—

(A) The plan required such a statement when the employee declined enrollment; and

(B) The employee is provided with notice of the requirement to provide the statement in this paragraph (a)(5)(i) (and the consequences of the employee's failure to provide the statement) at the time the employee declined enrollment.

(ii)(A) When the employee declined enrollment for the employee or dependent under the plan, the employee or dependent had COBRA continuation coverage under another plan and COBRA continuation coverage under that other plan has since been exhausted; or

(B) If the other coverage that applied to the employee or dependent when enrollment was declined was not under a COBRA continuation provision, either the other coverage has been terminated as a result of loss of eligibility for the coverage or employer contributions towards the other coverage have been terminated. For this purpose, loss of eligibility for coverage includes a loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing. Thus, for example, if an employee's coverage ceases following a termination of employment and the employee is eligible for but fails to elect COBRA continuation coverage,

this is treated as a loss of eligibility under this paragraph (a)(5)(ii)(B). However, loss of eligibility does not include a loss due to failure of the individual or the participant to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). In addition, for purposes of this paragraph (a)(5)(ii)(B), employer contributions include contributions by any current or former employer (of the individual or another person) that was contributing to coverage for the individual.

(6) *Length of special enrollment period.* The employee is required to request enrollment (for the employee or the employee's dependent, as described in paragraph (a) (2), (3), or (4) of this section) not later than 30 days after the exhaustion of the other coverage described in paragraph (a)(5)(ii)(A) of this section or termination of the other coverage as a result of the loss of eligibility for the other coverage for items described in paragraph (a)(5)(ii)(B) of this section or following the termination of employer contributions toward that other coverage. The plan may impose the same requirements that apply to employees who are otherwise eligible under the plan to immediately request enrollment for coverage (e.g., that the request be made in writing).

(7) *Effective date of enrollment.* Enrollment is effective not later than the first day of the first calendar month beginning after the date the completed request for enrollment is received.

(b) *Special enrollment with respect to certain dependent beneficiaries*—(1) *In general.* A group health plan that makes coverage available with respect to dependents of a participant is required to provide a special enrollment period to permit individuals described in paragraph (b) (2), (3), (4), (5), or (6) of this section to be enrolled for coverage under the terms of the plan if the enrollment is requested within the time period described in paragraph (b)(7) of this section. The enrollment is effective at the time described in paragraph (b)(8) of this section. The special enrollment rights under this paragraph (b) apply without regard to the dates on which an individual would otherwise be able to enroll under the plan.

(2) *Special enrollment of an employee who is eligible but not enrolled.* An individual is described in this paragraph (b)(2) if the individual is an employee who is eligible, but not enrolled, for coverage under the terms of the plan, the individual would be a participant but for a prior election by the individual not to enroll in the plan during a previous enrollment period, and a person becomes a dependent of the individual through marriage, birth, or adoption or placement for adoption.

(3) *Special enrollment of a spouse of a participant.* An individual is described in this paragraph (b)(3) if either—

(i) The individual becomes the spouse of a participant; or

(ii) The individual is a spouse of the participant and a child becomes a dependent of the participant through birth, adoption or placement for adoption.

(4) *Special enrollment of an employee who is eligible but not enrolled and the spouse of such employee.* An employee who is eligible, but not enrolled, for coverage under the terms of the plan, and an individual who is a dependent of such employee, are described in this paragraph (b)(4) if the employee would be a participant but for a prior election by the employee not to enroll in the plan during a previous enrollment period, and either—

(i) The employee and the individual become married; or

(ii) The employee and individual are married and a child becomes a dependent of the employee through birth, adoption or placement for adoption.

(5) *Special enrollment of a dependent of a participant.* An individual is described in this paragraph (b)(5) if the individual is a dependent of a participant and the individual becomes a dependent of such participant through marriage, birth, or adoption or placement for adoption.

(6) *Special enrollment of an employee who is eligible but not enrolled and a new dependent.* An employee who is eligible, but not enrolled, for coverage under the terms of the plan, and an individual who is a dependent of the employee, are described in this paragraph

(b)(6) if the employee would be a participant but for a prior election by the employee not to enroll in the plan during a previous enrollment period, and the dependent becomes a dependent of the employee through marriage, birth, or adoption or placement for adoption.

(7) *Length of special enrollment period.* The special enrollment period under paragraph (b)(1) of this section is a period of not less than 30 days and begins on the date of the marriage, birth, or adoption or placement for adoption (except that such period does not begin earlier than the date the plan makes dependent coverage generally available).

(8) *Effective date of enrollment.* Enrollment is effective—

(i) In the case of marriage, not later than the first day of the first calendar month beginning after the date the completed request for enrollment is received by the plan;

(ii) In the case of a dependent's birth, the date of such birth; and

(iii) In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

(9) *Example.* The rules of this paragraph (b) are illustrated by the following example:

Example. (i) Employee *A* is hired on September 3, 1998 by Employer *X*, which has a group health plan in which *A* can elect to enroll either for employee-only coverage, for employee-plus-spouse coverage, or for family coverage, effective on the first day of any calendar quarter thereafter. *A* is married and has no children. *A* does not elect to join Employer *X's* plan (for employee-only coverage, employee-plus-spouse coverage, or family coverage) on October 1, 1998 or January 1, 1999. On February 15, 1999, a child is placed for adoption with *A* and *A*'s spouse.

(ii) In this *Example*, the conditions for special enrollment of an employee with a new dependent under paragraph (b)(2) of this section are satisfied, the conditions for special enrollment of an employee and a spouse with a new dependent under paragraph (b)(4) of this section are satisfied, and the conditions for special enrollment of an employee and a new dependent under paragraph (b)(6) of this section are satisfied. Accordingly, Employer *X*'s plan will satisfy this paragraph (b) if and only if it allows *A* to elect, by filing the required forms by March 16, 1999, to enroll in Employer *X*'s plan either with employee-only coverage, with employee-plus-spouse coverage, or with family coverage, effective as of February 15, 1999.

(c) *Notice of enrollment rights.* On or before the time an employee is offered the opportunity to enroll in a group health plan, the plan is required to provide the employee with a description of the plan's special enrollment rules under this section. For this purpose, the plan may use the following model description of the special enrollment rules under this section:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

(d) (1) *Special enrollment date definition.* A special enrollment date for an individual means any date in paragraph (a)(7) or (b)(8) of this section on which the individual has a right to have enrollment in a group health plan become effective under this section.

(2) *Examples.* The rules of this section are illustrated by the following examples:

≤*Example 1.* (i)(A) Employer *Y* maintains a group health plan that allows employees to enroll in the plan either—

(*1*) Effective on the first day of employment by an election filed within three days thereafter;

(*2*) Effective on any subsequent January 1 by an election made during the preceding months of November or December; or

(*3*) Effective as of any special enrollment date described in this section.

(B) Employee *B* is hired by Employer *Y* on March 15, 1998 and does not elect to enroll in Employer *Y*'s plan until January 31, 1999 when *B* loses coverage under another plan. *B* elects to enroll in Employer *Y*'s plan effective on February 1, 1999, by filing the completed request form by January 31, 1999, in accordance with the special rule set forth in paragraph (a) of this section.

(ii) In this *Example 1*, *B* has enrolled on a special enrollment date because the enrollment is effective at a date described in paragraph (a)(7) of this section.

Example 2. (i) Same facts as *Example 1*, except that *B*'s loss of coverage under the

other plan occurs on December 31, 1998 and *B* elects to enroll in Employer *Y*'s plan effective on January 1, 1999 by filing the completed request form by December 31, 1998, in accordance with the special rule set forth in paragraph (a) of this section.

(ii) In this *Example 2*, *B* has enrolled on a special enrollment date because the enrollment is effective at a date described in paragraph (a)(7) of this section (even though this date is also a regular enrollment date under the plan).

[T.D. 8716, 62 FR 16937, Apr. 8, 1997; 62 FR 31669, 31692, June 10, 1997]

§ 54.9802–1 Prohibiting discrimination against participants and beneficiaries based on a health factor.

(a) *Health factors.* (1) The term *health factor* means, in relation to an individual, any of the following health status-related factors:

(i) Health status;

(ii) Medical condition (including both physical and mental illnesses);

(iii) Claims experience;

(iv) Receipt of health care;

(v) Medical history;

(vi) Genetic information;

(vii) Evidence of insurability; or

(viii) Disability.

(2) Evidence of insurability includes—

(i) Conditions arising out of acts of domestic violence; and

(ii) [Reserved]. For further guidance, see § 54.9802–1T(a)(2)(ii).

(b) *Prohibited discrimination in rules for eligibility*—(1) *In general.* (i) A group health plan may not establish any rule for eligibility (including continued eligibility) of any individual to enroll for benefits under the terms of the plan that discriminates based on any health factor that relates to that individual or a dependent of that individual. This rule is subject to the provisions of paragraph (b)(2) of this section (explaining how this rule applies to benefits), paragraph (b)(3) of this section (allowing plans to impose certain preexisting condition exclusions), paragraph (d) of this section (containing rules for establishing groups of similarly situated individuals), paragraph (e) of this section (relating to nonconfinement, actively-at-work, and other service requirements), paragraph (f) of this section (relating to bona fide wellness programs), and paragraph (g) of this section (permitting favorable treatment of individuals with adverse health factors).

(ii) [Reserved]. For further guidance, see § 54.9802–1T(b)(1)(ii).

(iii) The rules of this paragraph (b)(1) are illustrated by the following examples:

Example 1. (i) *Facts.* An employer sponsors a group health plan that is available to all employees who enroll within the first 30 days of their employment. However, employees who do not enroll within the first 30 days cannot enroll later unless they pass a physical examination.

(ii) *Conclusion.* In this *Example 1*, the requirement to pass a physical examination in order to enroll in the plan is a rule for eligibility that discriminates based on one or more health factors and thus violates this paragraph (b)(1).

Example 2. [Reserved]

(2) *Application to benefits*—(i) *General rule.* (A) Under this section, a group health plan is not required to provide coverage for any particular benefit to any group of similarly situated individuals.

(B) [Reserved]. For further guidance, see § 54.9802–1T(b)(2)(i)(B).

(C) [Reserved]. For further guidance, see § 54.9802–1T(b)(2)(i)(C).

(D) [Reserved]. For further guidance, see § 54.9802–1T(b)(2)(i)(D).

(ii) *Cost-sharing mechanisms and wellness programs.* A group health plan with a cost-sharing mechanism (such as a deductible, copayment, or coinsurance) that requires a higher payment from an individual, based on a health factor of that individual or a dependent of that individual, than for a similarly situated individual under the plan (and thus does not apply uniformly to all similarly situated individuals) does not violate the requirements of this paragraph (b)(2) if the payment differential is based on whether an individual has complied with the requirements of a bona fide wellness program.

(iii) *Specific rule relating to source-of-injury exclusions.* [Reserved]. For further guidance, see § 54.9802–1T(b)(2)(iii).

(3) *Relationship to section 9801(a), (b), and (d).* [Reserved]. For further guidance, see § 54.9802–1T(b)(3).

(c) *Prohibited discrimination in premiums or contributions*—(1) *In general.* (i) A group health plan may not require an individual, as a condition of enrollment or continued enrollment under

the plan, to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual (described in paragraph (d) of this section) enrolled in the plan based on any health factor that relates to the individual or a dependent of the individual.

(ii) [Reserved]. For further guidance, see § 54.9802–1T(c)(1)(ii).

(2) *Rules relating to premium rates*—(i) *Group rating based on health factors not restricted under this section.* Nothing in this section restricts the aggregate amount that an employer may be charged for coverage under a group health plan.

(ii) *List billing based on a health factor prohibited.* [Reserved]. For further guidance, see § 54.9802–1T(c)(2)(ii).

(3) *Exception for bona fide wellness programs.* Notwithstanding paragraphs (c)(1) and (2) of this section, a plan may establish a premium or contribution differential based on whether an individual has complied with the requirements of a bona fide wellness program.

(d) *Similarly situated individuals.* [Reserved]. For further guidance, see § 54.9802–1T(d).

(e) *Nonconfinement and actively-at-work provisions.* [Reserved]. For further guidance, see § 54.9802–1T(e).

(f) *Bona fide wellness programs.* [Reserved]

(g) *Benign discrimination permitted.* [Reserved]. For further guidance, see § 54.9802–1T(g).

(h) *No effect on other laws.* [Reserved]. For further guidance, see § 54.9802–1T(h).

(i) *Effective dates.* (1) Final rules apply May 8, 2001. This section applies May 8, 2001.

(2) *Cross-reference to temporary rules applicable for plan years beginning on or after July 1, 2001.* See § 54.9802–1T(i)(2), which makes the rules of that section applicable for plan years beginning on or after July 1, 2001.

(3) *Cross-reference to temporary transitional rules for individuals previously denied coverage based on a health factor.* See § 54.9802–1T(i)(3) for transitional rules that apply with respect to individuals previously denied coverage under a group health plan based on a health factor.

[T.D. 8931, 66 FR 1396, Jan. 8, 2001, as amended at 66 FR 14077, Mar. 9, 2001]

§ 54.9802–1T Prohibiting discrimination against participants and beneficiaries based on a health factor (temporary).

(a) *Health factors.* (1) [Reserved]. For further guidance, see § 54.9802–1(a).

(2) Evidence of insurability includes—

(i) [Reserved]. For further guidance, see § 54.9802–1(a)(2)(i).

(ii) Participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities.

(3) The decision whether health coverage is elected for an individual (including the time chosen to enroll, such as under special enrollment or late enrollment) is not, itself, within the scope of any health factor. (However, under section 9801(f) a plan must treat special enrollees the same as similarly situated individuals who are enrolled when first eligible.)

(b) *Prohibited discrimination in rules for eligibility*—(1) *In general.* (i) [Reserved]. For further guidance, see § 54.9802–1(b)(1)(i).

(ii) For purposes of this section, rules for eligibility include, but are not limited to, rules relating to—

(A) Enrollment;

(B) The effective date of coverage;

(C) Waiting (or affiliation) periods;

(D) Late and special enrollment;

(E) Eligibility for benefit packages (including rules for individuals to change their selection among benefit packages);

(F) Benefits (including rules relating to covered benefits, benefit restrictions, and cost-sharing mechanisms such as coinsurance, copayments, and deductibles), as described in paragraphs (b) (2) and (3) of this section;

(G) Continued eligibility; and

(H) Terminating coverage (including disenrollment) of any individual under the plan.

(iii) The rules of this paragraph (b)(1) are illustrated by the following examples:

Example 1. [Reserved]. For further guidance, see § 54.9802–1(b)(iii). *Example 1.*

Example 2. (i) *Facts.* Under an employer's group health plan, employees who enroll during the first 30 days of employment (and during special enrollment periods) may choose between two benefit packages: an indemnity option and an HMO option. However, employees who enroll during late enrollment are permitted to enroll only in the HMO option and only if they provide evidence of good health.

(ii) *Conclusion.* In this *Example 2,* the requirement to provide evidence of good health in order to be eligible for late enrollment in the HMO option is a rule for eligibility that discriminates based on one or more health factors and thus violates this paragraph (b)(1). However, if the plan did not require evidence of good health but limited late enrollees to the HMO option, the plan's rules for eligibility would not discriminate based on any health factor, and thus would not violate this paragraph (b)(1), because the time an individual chooses to enroll is not, itself, within the scope of any health factor.

Example 3. (i) *Facts.* Under an employer's group health plan, all employees generally may enroll within the first 30 days of employment. However, individuals who participate in certain recreational activities, including motorcycling, are excluded from coverage.

(ii) *Conclusion.* In this *Example 3,* excluding from the plan individuals who participate in recreational activities, such as motorcycling, is a rule for eligibility that discriminates based on one more health factors and thus violates this paragraph (b)(1).

Example 4. (i) *Facts.* A group health plan applies for a group health policy offered by an issuer. As part of the application, the issuer receives health information about individuals to be covered under the plan. Individual *A* is an employee of the employer maintaining the plan. *A* and *A*'s dependents have a history of high health claims. Based on the information about *A* and *A*'s dependents, the issuer excludes *A* and *A*'s dependents from the group policy it offers to the employer.

(ii) *Conclusion.* See *Example 4* in 29 CFR 2590.702(b)(1) and 45 CFR 146.121(b)(1) for a conclusion that the exclusion by the issuer of *A* and *A*'s dependents from coverage is a rule for eligibility that discriminates based on one or more health factors and violates rules under 29 CFR 2590.702(b)(1) and 45 CFR 146.121(b)(1) similar to the rules under this paragraph (b)(1). (If the employer is a small employer under 45 CFR 144.103 (generally, an employer with 50 or fewer employees), the issuer also may violate 45 CFR 146.150, which requires issuers to offer all the policies they sell in the small group market on a guaranteed available basis to all small employers and to accept every eligible individual in every small employer group.) If the plan provides coverage through this policy and does not provide equivalent coverage for *A* and *A*'s dependents through other means, the plan will also violate this paragraph (b)(1).

(2) *Application to benefits*—(i) *General rule.* (A) [Reserved]. For further guidance, see § 54.9802–1(b)(2)(i)(A).

(B) However, benefits provided under a plan must be uniformly available to all similarly situated individuals (as described in paragraph (d) of this section). Likewise, any restriction on a benefit or benefits must apply uniformly to all similarly situated individuals and must not be directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries (determined based on all the relevant facts and circumstances). Thus, for example, a plan may limit or exclude benefits in relation to a specific disease or condition, limit or exclude benefits for certain types of treatments or drugs, or limit or exclude benefits based on a determination of whether the benefits are experimental or not medically necessary, but only if the benefit limitation or exclusion applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. In addition, a plan may impose annual, lifetime, or other limits on benefits and may require the satisfaction of a deductible, copayment, coinsurance, or other cost-sharing requirement in order to obtain a benefit if the limit or cost-sharing requirement applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. In the case of a cost-sharing requirement, see also paragraph (b)(2)(ii) of this section, which permits variances in the application of a cost-sharing mechanism made available under a bona fide wellness program. (Whether any plan provision or practice with respect to benefits complies with this paragraph (b)(2)(i) does not affect whether the provision or practice is permitted under any other provision of the Code, the Americans with Disabilities Act, or any other law, whether State or federal.)

(C) For purposes of this paragraph (b)(2)(i), a plan amendment applicable

to all individuals in one or more groups of similarly situated individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at any individual participants or beneficiaries.

(D) The rules of this paragraph (b)(2)(i) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan applies a $500,000 lifetime limit on all benefits to each participant or beneficiary covered under the plan. The limit is not directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 1*, the limit does not violate this paragraph (b)(2)(i) because $500,000 of benefits are available uniformly to each participant and beneficiary under the plan and because the limit is applied uniformly to all participants and beneficiaries and is not directed at individual participants or beneficiaries.

Example 2. (i) *Facts.* A group health plan has a $2 million lifetime limit on all benefits (and no other lifetime limits) for participants covered under the plan. Participant *B* files a claim for the treatment of AIDS. At the next corporate board meeting of the plan sponsor, the claim is discussed. Shortly thereafter, the plan is modified to impose a $10,000 lifetime limit on benefits for the treatment of AIDS, effective before the beginning of the next plan year.

(ii) *Conclusion.* Under the facts of this *Example 2*, the plan violates this paragraph (b)(2)(i) because the plan modification is directed at *B* based on *B*'s claim.

Example 3. (i) A group health plan applies for a group health policy offered by an issuer. Individual *C* is covered under the plan and has an adverse health condition. As part of the application, the issuer receives health information about the individuals to be covered, including information about *C*'s adverse health condition. The policy form offered by the issuer generally provides benefits for the adverse health condition that *C* has, but in this case the issuer offers the plan a policy modified by a rider that excludes benefits for *C* for that condition. The exclusionary rider is made effective the first day of the next plan year.

(ii) *Conclusion.* See *Example 3* in 29 CFR 2590.702(b)(2)(i) and 45 CFR 146.121(b)(2)(i) for a conclusion that the issuer violates rules under 29 CFR 2590.702(b)(2)(i) and 45 CFR 146.121(b)(2)(i) similar to the rules under this paragraph (b)(2)(i) because the rider excluding benefits for the condition that *C* has is directed at *C* even though it applies by its terms to all participants and beneficiaries under the plan.

Example 4. (i) *Facts.* A group health plan has a $2,000 lifetime limit for the treatment of temporomandibular joint syndrome (TMJ). The limit is applied uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 4*, the limit does not violate this paragraph (b)(2)(i) because $2000 of benefits for the treatment of TMJ are available uniformly to all similarly situated individuals and a plan may limit benefits covered in relation to a specific disease or condition if the limit applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

Example 5. (i) *Facts.* A group health plan applies a $2 million lifetime limit on all benefits. However, the $2 million lifetime limit is reduced to $10,000 for any participant or beneficiary covered under the plan who has a congenital heart defect.

(ii) *Conclusion.* In this *Example 5*, the lower lifetime limit for participants and beneficiaries with a congenital heart defect violates this paragraph (b)(2)(i) because benefits under the plan are not uniformly available to all similarly situated individuals and the plan's lifetime limit on benefits does not apply uniformly to all similarly situated individuals.

Example 6. (i) *Facts.* A group health plan limits benefits for prescription drugs to those listed on a drug formulary. The limit is applied uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 6*, the exclusion from coverage of drugs not listed on the drug formulary does not violate this paragraph (b)(2)(i) because benefits for prescription drugs listed on the formulary are uniformly available to all similarly situated individuals and because the exclusion of drugs not listed on the formulary applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

Example 7. (i) *Facts.* Under a group health plan, doctor visits are generally subject to a $250 annual deductible and 20 percent coinsurance requirement. However, prenatal doctor visits are not subject to any deductible or coinsurance requirement. These rules are applied uniformly to all similarly situated individuals and are not directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 7*, imposing different deductible and coinsurance requirements for prenatal doctor visits and other visits does not violate this paragraph (b)(2)(i) because a plan may establish different deductibles or coinsurance requirements for different services if the deductible or coinsurance requirement is applied uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

(ii) *Cost-sharing mechanisms and wellness programs.* [Reserved]. For further guidance, see § 54.9802–1(b)(2)(ii).

(iii) *Specific rule relating to source-of-injury exclusions*—(A) If a group health plan generally provides benefits for a type of injury, the plan may not deny benefits otherwise provided for treatment of the injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

(B) The rules of this paragraph (b)(2)(iii) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan generally provides medical/surgical benefits, including benefits for hospital stays, that are medically necessary. However, the plan excludes benefits for self-inflicted injuries or injuries sustained in connection with attempted suicide. Individual *D* suffers from depression and attempts suicide. As a result, *D* sustains injuries and is hospitalized for treatment of the injuries. Pursuant to the exclusion, the plan denies *D* benefits for treatment of the injuries.

(ii) *Conclusion.* In this *Example 1,* the suicide attempt is the result of a medical condition (depression). Accordingly, the denial of benefits for the treatments of *D*'s injuries violates the requirements of this paragraph (b)(2)(iii) because the plan provision excludes benefits for treatment of an injury resulting from a medical condition.

Example 2. (i) *Facts.* A group health plan provides benefits for head injuries generally. The plan also has a general exclusion for any injury sustained while participating in any of a number of recreational activities, including bungee jumping. However, this exclusion does not apply to any injury that results from a medical condition (nor from domestic violence). Participant *E* sustains a head injury while bungee jumping. The injury did not result from a medical condition (nor from domestic violence). Accordingly, the plan denies benefits for *E*'s head injury.

(ii) *Conclusion.* In this *Example 2,* the plan provision that denies benefits based on the source of an injury does not restrict benefits based on an act of domestic violence or any medical condition. Therefore, the provision is permissible under this paragraph (b)(2)(iii) and does not violate this section. (However, if the plan did not allow *E* to enroll in the plan (or applied different rules for eligibility to *E*) because *E* frequently participates in bungee jumping, the plan would violate paragraph (b)(1) of this section.)

(3) *Relationship to section 9801(a), (b), and (d).* (i) A preexisting condition exclusion is permitted under this section if it—

(A) Complies with section 9801(a), (b), and (d);

(B) Applies uniformly to all similarly situated individuals (as described in paragraph (d) of this section); and

(C) Is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. For purposes of this paragraph (b)(3)(i)(C), a plan amendment relating to a preexisting condition exclusion applicable to all individuals in one or more groups of similarly situated individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at any individual participants or beneficiaries.

(ii) The rules of this paragraph (b)(3) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan imposes a preexisting condition exclusion on all individuals enrolled in the plan. The exclusion applies to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on an individual's enrollment date. In addition, the exclusion generally extends for 12 months after an individual's enrollment date, but this 12-month period is offset by the number of days of an individual's creditable coverage in accordance with section 9801(a). There is nothing to indicate that the exclusion is directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 1,* even though the plan's preexisting condition exclusion discriminates against individuals based on one or more health factors, the preexisting condition exclusion does not violate this section because it applies uniformly to all similarly situated individuals, is not directed at individual participants or beneficiaries, and complies with section 9801(a), (b), and (d) (that is, the requirements relating to the six-month look-back period, the 12-month (or 18-month) maximum exclusion period, and the creditable coverage offset).

Example 2. (i) *Facts.* A group health plan excludes coverage for conditions with respect to which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on an individual's enrollment date. Under the plan, the preexisting condition exclusion generally extends for 12 months, offset by creditable coverage. However, if an individual has no

claims in the first six months following enrollment, the remainder of the exclusion period is waived.

(ii) *Conclusion.* In this *Example 2*, the plan's preexisting condition exclusions violate this section because they do not meet the requirements of this paragraph (b)(3); specifically, they do not apply uniformly to all similarly situated individuals. The plan provisions do not apply uniformly to all similarly situated individuals because individuals who have medical claims during the first six months following enrollment are not treated the same as similarly situated individuals with no claims during that period. (Under paragraph (d) of this section, the groups cannot be treated as two separate groups of similarly situated individuals because the distinction is based on a health factor.)

(c) *Prohibited discrimination in premiums or contributions*—(1) *In general.* (i) [Reserved]. For further guidance, see § 54.9802–1(c)(1)(i).

(ii) Discounts, rebates, payments in kind, and any other premium differential mechanisms are taken into account in determining an individual's premium or contribution rate. (For rules relating to cost-sharing mechanisms, see paragraph (b)(2) of this section (addressing benefits).)

(2) *Rules relating to premium rates*—(i) *Group rating based on health factors not restricted under this section.* [Reserved]. For further guidance, see § 54.9802–1(c)(1)(i).

(ii) *List billing based on a health factor prohibited.* However, a group health plan may not quote or charge an employer (or an individual) a different premium for an individual in a group of similarly situated individuals based on a health factor. (But see paragraph (g) of this section permitting favorable treatment of individuals with adverse health factors.)

(iii) *Examples.* The rules of this paragraph (c)(2) are illustrated by the following examples:

Example 1. (i) *Facts.* An employer sponsors a group health plan and purchases coverage from a health insurance issuer. In order to determine the premium rate for the upcoming plan year, the issuer reviews the claims experience of individuals covered under the plan. The issuer finds that Individual F had significantly higher claims experience than similarly situated individuals in the plan. The issuer quotes the plan a higher per-participant rate because of *F*'s claims experience.

(ii) *Conclusion.* See *Example 1* in 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) for a conclusion that the issuer does not violate the provisions of 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) similar to the provisions of this paragraph (c)(2) because the issuer blends the rate so that the employer is not quoted a higher rate for *F* than for a similarly situated individual based on *F*'s claims experience.

Example 2. (i) *Facts.* Same facts as *Example 1*, except that the issuer quotes the employer a higher premium rate for *F*, because of *F*'s claims experience, than for a similarly situated individual.

(ii) *Conclusion.* See *Example 2* in 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) for a conclusion that the issuer violates provisions of 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) similar to the provisions of this paragraph (c)(2). Moreover, even if the plan purchased the policy based on the quote but did not require a higher participant contribution for *F* than for a similarly situated individual, see *Example 2* in 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) for a conclusion that the issuer would still violate 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) (but in such a case the plan would not violate this paragraph (c)(2)).

(3) *Exception for bona fide wellness programs.* [Reserved]. For further guidance, see § 54.9802–1(c)(3).

(d) *Similarly situated individuals.* The requirements of this section apply only within a group of individuals who are treated as similarly situated individuals. A plan may treat participants as a group of similarly situated individuals separate from beneficiaries. In addition, participants may be treated as two or more distinct groups of similarly situated individuals and beneficiaries may be treated as two or more distinct groups of similarly situated individuals in accordance with the rules of this paragraph (d). Moreover, if individuals have a choice of two or more benefit packages, individuals choosing one benefit package may be treated as one or more groups of similarly situated individuals distinct from individuals choosing another benefit package.

(1) *Participants.* Subject to paragraph (d)(3) of this section, a plan may treat participants as two or more distinct groups of similarly situated individuals if the distinction between or among the groups of participants is based on a bona fide employment-based classification consistent with the employer's usual business practice. Whether an

employment-based classification is bona fide is determined on the basis of all the relevant facts and circumstances. Relevant facts and circumstances include whether the employer uses the classification for purposes independent of qualification for health coverage (for example, determining eligibility for other employee benefits or determining other terms of employment). Subject to paragraph (d)(3) of this section, examples of classifications that, based on all the relevant facts and circumstances, may be bona fide include full-time versus part-time status, different geographic location, membership in a collective bargaining unit, date of hire, length of service, current employee versus former employee status, and different occupations. However, a classification based on any health factor is not a bona fide employment-based classification, unless the requirements of paragraph (g) of this section are satisfied (permitting favorable treatment of individuals with adverse health factors).

(2) *Beneficiaries*—(i) Subject to paragraph (d)(3) of this section, a plan may treat beneficiaries as two or more distinct groups of similarly situated individuals if the distinction between or among the groups of beneficiaries is based on any of the following factors:

(A) A bona fide employment-based classification of the participant through whom the beneficiary is receiving coverage;

(B) Relationship to the participant (*e.g.*, as a spouse or as a dependent child);

(C) Marital status;

(D) With respect to children of a participant, age or student status; or

(E) Any other factor if the factor is not a health factor.

(ii) Paragraph (d)(2)(i) of this section does not prevent more favorable treatment of beneficiaries with adverse health factors in accordance with paragraph (g) of this section.

(3) *Discrimination directed at individuals.* Notwithstanding paragraphs (d)(1) and (2) of this section, if the creation or modification of an employment or coverage classification is directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries, the classification is not permitted under this paragraph (d), unless it is permitted under paragraph (g) of this section (permitting favorable treatment of individuals with adverse health factors). Thus, if an employer modified an employment-based classification to single out, based on a health factor, individual participants and beneficiaries and deny them health coverage, the new classification would not be permitted under this section.

(4) *Examples.* The rules of this paragraph (d) are illustrated by the following examples:

Example 1. (i) *Facts.* An employer sponsors a group health plan for full-time employees only. Under the plan (consistent with the employer's ususal business practice), employees who normally work at least 30 hours per week are considered to be working full-time. Other employees are considered to be working part-time. There is no evidence to suggest that the classification is directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 1,* treating the full-time and part-time employees as two separate groups of similarly situated individuals is permitted under this paragraph (d) because the classification is bona fide and is not directed at individual participants or beneficiaries.

Example 2. (i) *Facts.* Under a group health plan, coverage is made available to employees, their spouses, and their dependent children. However, coverage is made available to a dependent child only if the dependent child is under age 19 (or under age 25 if the child is continuously enrolled full-time in an institution of higher learning (full-time students)). There is no evidence to suggest that these classifications are directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 2,* treating spouses and dependent children differently by imposing an age limitation on dependent children, but not on spouses, is permitted under this paragraph (d). Specifically, the distinction between spouses and dependent children is permitted under paragraph (d)(2) of this section and is not prohibited under paragraph (d)(3) of this section because it is not directed at individual participants or beneficiaries. It is also permissible to treat dependent children who are under age 19 (or full-time students under age 25) as a group of similarly situated individuals separate from those who are age 25 or older (or age 19 or older if they are not full-time students) because the classification is permitted under paragraph (d)(2) of this section and is not directed at individual participants or beneficiaries.

Example 3. (i) *Facts.* A university sponsors a group health plan that provides one health benefit package to faculty and another health benefit package to other staff. Faculty and staff are treated differently with respect to other employee benefits such as retirement benefits and leaves of absence. There is no evidence to suggest that the distinction is directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 3,* the classification is permitted under this paragraph (d) because there is a distinction based on a bona fide employment-based classification consistent with the employer's usual business practice and the distinction is not directed at individual participants and beneficiaries.

Example 4. (i) *Facts.* An employer sponsors a group health plan that is available to all current employees. Former employees may also be eligible, but only if they complete a specified number of years of service, are enrolled under the plan at the time of termination of employment, and are continuously enrolled from that date. There is no evidence to suggest that these distinctions are directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 4,* imposing additional eligibility requirements on former employees is permitted because a classification that distinguishes between current and former employees is a bona fide employment-based classification that is permitted under this paragraph (d), provided that it is not directed at individual participants or beneficiaries. In addition, it is permissible to distinguish between former employees who satisfy the service requirement and those who do not, provided that the distinction is not directed at individual participants or beneficiaries. (However, former employees who do not satisfy the eligibility criteria may, nonetheless, be eligible for continued coverage pursuant to a COBRA continuation provision or similar State law.)

Example 5. (i) *Facts.* An employer sponsors a group health plan that provides the same benefit package to all seven employees of the employer. Six of the seven employees have the same job title and responsibilities, but Employee *G* has a different job title and different responsibilities. After *G* files an expensive claim for benefits under the plan, coverage under the plan is modified so that employees with *G*'s job title receive a different benefit package that includes a lower lifetime dollar limit than in the benefit package made available to the other six employees.

(ii) *Conclusion.* Under the facts of this *Example 5,* changing the coverage classification for *G* based on the existing employment classification for *G* is not permitted under this paragraph (d) because the creation of the new coverage classification for *G* is directed at *G* based on one or more health factors.

(e) *Nonconfinement and actively-at-work provisions*—(1) *Nonconfinement provisions*—(i) *General rule.* Under the rules of paragraphs (b) and (c) of this section, a plan may not establish a rule for eligibility (as described in paragraph (b)(1)(ii) of this section) or set any individual's premium or contribution rate based on whether an individual is confined to a hospital or other health care institution. In addition, under the rules of paragraphs (b) and (c) of this section, a plan may not establish a rule for eligibility or set any individual's premium or contribution rate based on an individual's ability to engage in normal life activities, except to the extent permitted under paragraphs (e)(2)(ii) and (3) of this section (permitting plans, under certain circumstances, to distinguish among employees based on the performance of services).

(ii) *Examples.* The rules of this paragraph (e)(1) are illustrated by the following examples:

Example 1. (i) *Facts.* Under a group health plan, coverage for employees and their dependents generally becomes effective on the first day of employment. However, coverage for a dependent who is confined to a hospital or other health care institution does not become effective until the confinement ends.

(ii) *Conclusion.* In this *Example 1,* the plan violates this paragraph (e)(1) because the plan delays the effective date of coverage for dependents based on confinement to a hospital or other health care institution.

Example 2. (i) *Facts.* In previous years, a group health plan has provided coverage through a group health insurance policy offered by Issuer *M.* However, for the current year, the plan provides coverage through a group health insurance policy offered by Issuer *N.* Under Issuer *N*'s policy, items and services provided in connection with the confinement of a dependent to a hospital or other health care institution are not covered if the confinement is covered under an extension of benefits clause from a previous health insurance issuer.

(ii) *Conclusion.* See *Example 2* in 29 CFR 2590.702(e)(1) and 45 CFR 146.121(e)(1) for a conclusion that Issuer *N* violates provisions of 29 CFR 2590.702(e)(1) and 45 CFR 146.121(e)(1) similar to the provisions of this paragraph (e)(1) because Issuer *N* restricts benefits based on whether a dependent is confined to a hospital or other health care

institution that is covered under an extension of benefits from a previous issuer.

(2) *Actively-at-work and continuous service provisions*—(i) *General rule.* (A) Under the rules of paragraphs (b) and (c) of this section and subject to the exception for the first day of work in paragraph (e)(2)(ii) of this section, a plan may not establish a rule for eligibility (as described in paragraph (b)(1)(ii) of this section) or set any individual's premium or contribution rate based on whether an individual is actively at work (including whether an individual is continuously employed), unless absence from work due to any health factor (such as being absent from work on sick leave) is treated, for purposes of the plan, as being actively at work.

(B) The rules of this paragraph (e)(2)(i) are illustrated by the following examples:

Example 1. (i) *Facts.* Under a group health plan, an employee generally becomes eligible to enroll 30 days after the first day of employment. However, if the employee is not actively at work on the first day after the end of the 30-day period, then eligibility for enrollment is delayed until the first day the employee is actively at work.

(ii) *Conclusion.* In this *Example 1*, the plan violates this paragraph (e)(2) (and thus also violates paragraph (b) of this section). However, the plan would not violate paragraph (e)(2) or (b) of this section if, under the plan, an absence due to any health factor is considered being actively at work.

Example 2. (i) *Facts.* Under a group health plan, coverage for an employee becomes effective after 90 days of continuous service; that is, if an employee is absent from work (for any reason) before completing 90 days of service, the beginning of the 90-day period is measured from the day the employee returns to work (without any credit for service before the absence).

(ii) *Conclusion.* In this *Example 2*, the plan violates this paragraph (e)(2) (and thus also paragraph (b) of this section) because the 90-day continuous service requirement is a rule for eligibility based on whether an individual is actively at work. However, the plan would not violate this paragraph (e)(2) or paragraph (b) of this section if, under the plan, an absence due to any health factor is not considered an absence for purposes of measuring 90 days of continuous service.

(ii) *Exception for the first day of work.* (A) Notwithstanding the general rule in paragraph (e)(2)(i) of this section, a plan may establish a rule for eligibility that requires an individual to begin work for the employer sponsoring the plan (or, in the case of a multiemployer plan, to begin a job in covered employment) before coverage becomes effective, provided that such a rule for eligibility applies regardless of the reason for the absence.

(B) The rules of this paragraph (e)(2)(ii) are illustrated by the following examples:

Example 1. (i) *Facts.* Under the eligibility provision of a group health plan, coverage for new employees becomes effective on the first day that the employee reports to work. Individual *H* is scheduled to begin work on August 3. However, *H* is unable to begin work on that day because of illness. *H* begins working on August 4, and *H*'s coverage is effective on August 4.

(ii) *Conclusion.* In this *Example 1*, the plan provision does not violate this section. However, if coverage for individuals who do not report to work on the first day they were scheduled to work for a reason unrelated to a health factor (such as vacation or bereavement) becomes effective on the first day they were scheduled to work, then the plan would violate this section.

Example 2. (i) *Facts.* Under a group health plan, coverage for new employees becomes effective on the first day of the month following the employee's first day of work, regardless of whether the employee is actively at work on the first day of the month. Individual *J* is scheduled to begin work on March 24. However, *J* is unable to begin work on March 24 because of illness. *J* begins working on April 7 and *J*'s coverage is effective May 1.

(ii) *Conclusion.* In this *Example 2*, the plan provision does not violate this section. However, as in *Example 1*, if coverage for individuals absent from work for reasons unrelated to a health factor became effective despite their absence, then the plan would violate this section.

(3) *Relationship to plan provisions defining similarly situated individuals.* (i) Notwithstanding the rules of paragraphs (e)(1) and (2) of this section, a plan may establish rules for eligibility or set any individual's premium or contribution rate in accordance with the rules relating to similarly situated individuals in paragraph (d) of this section. Accordingly, a plan may distinguish in rules for eligibility under the plan between full-time and part-time employees, between permanent and temporary or seasonal employees, between current and former employees,

and between employees currently performing services and employees no longer performing services for the employer, subject to paragraph (d) of this section. However, other federal or State laws (including the COBRA continuation provisions and the Family and Medical Leave Act of 1993) may require an employee or the employee's dependents to be offered coverage and set limits on the premium or contribution rate even though the employee is not performing services.

(ii) The rules of this paragraph (e)(3) are illustrated by the following examples:

Example 1. (i) *Facts.* Under a group health plan, employees are eligible for coverage if they perform services for the employer for 30 or more hours per week or if they are on paid leave (such as annual, sick, or bereavement leave). Employees on unpaid leave are treated as a separate group of similarly situated individuals in accordance with the rules of paragraph (d) of this section.

(ii) *Conclusion.* In this *Example 1,* the plan provisions do not violate this section. However, if the plan treated individuals performing services for the employer for 30 or more hours per week, individuals on annual leave, and individuals on bereavement leave as a group of similarly situated individuals separate from individuals on sick leave, the plan would violate this paragraph (e) (and thus also would violate paragraph (b) of this section) because groups of similarly situated individuals cannot be established based on a health factor (including the taking of sick leave) under paragraph (d) of this section.

Example 2. (i) *Facts.* To be eligible for coverage under a bona fide collectively bargained group health plan in the current calendar quarter, the plan requires an individual to have worked 250 hours in covered employment during the three-month period that ends one month before the beginning of the current calendar quarter. The distinction between employees working at least 250 hours and those working less than 250 hours in the earlier three-month period is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries.

(ii) *Conclusion.* In this *Example 2,* the plan provision does not violate this section because, under the rules for similarly situated individuals allowing full-time employees to be treated differently than part-time employees, employees who work at least 250 hours in a three-month period can be treated differently than employees who fail to work 250 hours in that period. The result would be the same if the plan permitted individuals to apply excess hours from previous periods to satisfy the requirement for the current quarter.

Example 3. (i) *Facts.* Under a group health plan, coverage of an employee is terminated when the individual's employment is terminated, in accordance with the rules of paragraph (d) of this section. Employee *B* has been covered under the plan. *B* experiences a disabling illness that prevents *B* from working. *B* takes a leave of absence under the Family and Medical Leave Act of 1993. At the end of such leave, *B* terminates employment and consequently loses coverage under the plan. (This termination of coverage is without regard to whatever rights the employee (or members of the employee's family) may have for COBRA continuation coverage.)

(ii) *Conclusion.* In this *Example 3,* the plan provision terminating *B*'s coverage upon *B*'s termination of employment does not violate this section.

Example 4. (i) *Facts.* Under a group health plan, coverage of an employee is terminated when the employee ceases to perform services for the employer sponsoring the plan, in accordance with the rules of paragraph (d) of this section. Employee *C* is laid off for three months. When the layoff begins, *C*'s coverage under the plan is terminated. (This termination of coverage is without regard to whatever rights the employee (or members of the employee's family) may have for COBRA continuation coverage.)

(ii) *Conclusion.* In this *Example 4,* the plan provision terminating *C*'s coverage upon the cessation of *C*'s performance of services does not violate this section.

(f) *Bona fide wellness programs.* [Reserved]

(g) *More favorable treatment of individuals with adverse health factors permitted*—(1) *In rules for eligibility.* (i) Nothing in this section prevents a group health plan from establishing more favorable rules for eligibility (described in paragraph (b)(1) of this section) for individuals with an adverse health factor, such as disability, than for individuals without the adverse health factor. Moreover, nothing in this section prevents a plan from charging a higher premium or contribution with respect to individuals with an adverse health factor if they would not be eligible for the coverage were it not for the adverse health factor. (However, other laws, including State insurance laws, may set or limit premium rates; these laws are not affected by this section.)

(ii) The rules of this paragraph (g)(1) are illustrated by the following examples:

Example 1. (i) *Facts.* An employer sponsors a group health plan that generally is available to employees, spouses of employees, and dependent children until age 23. However, dependent children who are disabled are eligible for coverage beyond age 23.

(ii) *Conclusion.* In this *Example 1,* the plan provision allowing coverage for disabled dependent children beyond age 23 satisfies this paragraph (g)(1) (and thus does not violate this section).

Example 2. (i) *Facts.* An employer sponsors a group health plan, which is generally available to employees (and members of the employee's family) until the last day of the month in which the employee ceases to perform services for the employer. The plan generally charges employees $50 per month for employee-only coverage and $125 per month for family coverage. However, an employee who ceases to perform services for the employer by reason of disability may remain covered under the plan until the last day of the month that is 12 months after the month in which the employee ceased to perform services for the employer. During this extended period of coverage, the plan charges the employee $100 per month for employee-only coverage and $250 per month for family coverage. (This extended period of coverage is without regard to whatever rights the employee (or members of the employee's family) may have for COBRA continuation coverage.)

(ii) *Conclusion.* In this *Example 2,* the plan provision allowing extended coverage for disabled employees and their families satisfies this paragraph (g)(1) (and thus does not violate this section). In addition, the plan is permitted, under this paragraph (g)(1), to charge the disabled employees a higher premium during the extended period of coverage.

Example 3. (i) *Facts.* To comply with the requirements of a COBRA continuation provision, a group health plan generally makes COBRA continuation coverage available for a maximum period of 18 months in connection with a termination of employment but makes the coverage available for a maximum period of 29 months to certain disabled individuals and certain members of the disabled individual's family. Although the plan generally requires payment of 102 percent of the applicable premium for the first 18 months of COBRA continuation coverage, the plan requires payment of 150 percent of the applicable premium for the disabled individual's COBRA continuation coverage during the disability extension if the disabled individual would not be entitled to COBRA continuation coverage but for the disability.

(ii) *Conclusion.* In this *Example 3,* the plan provision allowing extended COBRA continuation coverage for disabled individuals satisfies this paragraph (g)(1) (and thus does not violate this section). In addition, the plan is permitted, under this paragraph (g)(1), to charge the disabled individuals a higher premium for the extended coverage if the individuals would not be eligible for COBRA continuation coverage were it not for the disability. (Similarly, if the plan provided an extended period of coverage for disabled individuals pursuant to State law or plan provision rather than pursuant to a COBRA continuation coverage provision, the plan could likewise charge the disabled individuals a higher premium for the extended coverage.)

(2) *In premiums or contributions.* (i) Nothing in this section prevents a group health plan from charging individuals a premium or contribution that is less than the premium (or contribution) for similarly situated individuals if the lower charge is based on an adverse health factor, such as disability.

(ii) The rules of this paragraph (g)(2) are illustrated by the following example:

Example. (i) *Facts.* Under a group health plan, employees are generally required to pay $50 per month for employee-only coverage and $125 per month for family coverage under the plan. However, employees who are disabled receive coverage (whether employee-only or family coverage) under the plan free of charge.

(ii) *Conclusion.* In this *Example,* the plan provision waiving premium payment for disabled employees is permitted under this paragraph (g)(2) (and thus does not violate this section).

(h) *No effect on other laws.* Compliance with this section is not determinative of compliance with any other provision of the Code (including the COBRA continuation provisions) or any other State or federal law, such as the Americans with Disabilities Act. Therefore, although the rules of this section would not prohibit a plan or issuer from treating one group of similarly situated individuals differently from another (such as providing different benefit packages to current and former employees), other federal or State laws may require that two separate groups of similarly situated individuals be treated the same for certain purposes (such as making the same benefit package available to COBRA qualified beneficiaries as is made available to active employees). In addition, although this section generally does not impose new disclosure obligations on plans, this section does not affect any other laws, including those that require accurate

disclosures and prohibit intentional misrepresentation.

(i) *Effective dates.* (1) Final rules apply May 8, 2001. [Reserved]. For further guidance, see § 54.9802–1(i)(1).

(2) *This section applies for plan years beginning on or after July 1, 2001.* Except as provided in paragraph (i)(3) of this section, this section applies for plan years beginning on or after July 1, 2001. Except as provided in paragraph (i)(3) of this section, with respect to efforts to comply with section 9802 before the first plan year beginning on or after July 1, 2001, the Secretary will not take any enforcement action against a plan that has sought to comply in good faith with section 9802.

(3) *Transitional rules for individuals previously denied coverage based on a health factor.* This paragraph (i)(3) provides rules relating to individuals previously denied coverage under a group health plan based on a health factor of the individual. Paragraph (i)(3)(i) clarifies what constitutes a denial of coverage under this paragraph (i)(3). Paragraph (i)(3)(ii) of this section applies with respect to any individual who was denied coverage if the denial was not based on a good faith interpretation of section 9802 or the Secretary's published guidance. Under that paragraph, such an individual must be allowed to enroll retroactively to the effective date of section 9802, or, if later, the date the individual meets eligibility criteria under the plan that do not discriminate based on any health factor. Paragraph (i)(3)(iii) of this section applies with respect to any individual who was denied coverage based on a good faith interpretation of section 9802 or the Secretary's published guidance. Under that paragraph, such an individual must be given an opportunity to enroll effective July 1, 2001. In either event, whether under paragraph (i)(3)(ii) or (iii) of this section, the Secretary will not take any enforcement action with respect to denials of coverage addressed in this paragraph (i)(3) if the plan has complied with the transitional rules of this paragraph (i)(3).

(i) *Denial of coverage clarified.* For purposes of this paragraph (i)(3), an individual is considered to have been denied coverage if the individual—

(A) Failed to apply for coverage because it was reasonable to believe that an application for coverage would have been futile due to a plan provision that discriminated based on a health factor; or

(B) Was not offered an opportunity to enroll in the plan and the failure to give such an opportunity violates this section.

(ii) *Individuals denied coverage without a good faith interpretation of the law—* (A) *Opportunity to enroll required.* If a plan has denied coverage to any individual based on a health factor and that denial was not based on a good faith interpretation of section 9802 or any guidance published by the Secretary, the plan is required to give the individual an opportunity to enroll (including notice of an opportunity to enroll) that continues for at least 30 days. This opportunity must be presented not later than May 8, 2001.

(*1*) If this enrollment opportunity was presented before or within the first plan year beginning on or after July 1, 1997 (or in the case of a collectively bargained plan, before or within the first plan year beginning on the effective date for the plan described in section 401(c)(3) of the Health Insurance Portability and Accountability Act of 1996), the coverage must be effective within that first plan year.

(*2*) If this enrollment opportunity is presented after such plan year, the individual must be given the choice of having the coverage effective on either of the following two dates—

(*i*) The date the plan receives a request for enrollment in connection with the enrollment opportunity; or

(*ii*) Retroactively to the first day of the first plan year beginning on the effective date for the plan described in section 401(c)(1) or (3) of the Health Insurance Portability and Accountability Act of 1996 (or, if the individual otherwise first became eligible to enroll for coverage after that date, on the date the individual was otherwise eligible to enroll in the plan). If an individual elects retroactive coverage, the plan is required to provide the benefits it would have provided if the individual had been enrolled for coverage during

that period (irrespective of any otherwise applicable plan provisions governing timing for the submission of claims). The plan may require the individual to pay whatever additional amount the individual would have been required to pay for the coverage (but the plan cannot charge interest on that amount).

(B) *Relation to preexisting condition rules.* For purposes of Chapter 100 of Subtitle K, the individual may not be treated as a late enrollee or as a special enrollee. Moreover, the individual's enrollment date is the effective date for the plan described in section 401(c)(1) or (3) of the Health Insurance Portability and Accountability Act of 1996 (or, if the individual otherwise first became eligible to enroll for coverage after that date, on the date the individual was otherwise eligible to enroll in the plan), even if the individual chooses under paragraph (i)(3)(ii)(A) of this section to have coverage effective only prospectively. In addition, any period between the individual's enrollment date and the effective date of coverage is treated as a waiting period.

(C) *Examples.* The rules of this paragraph (i)(3)(ii) are illustrated by the following examples:

Example 1. (i) *Facts.* Employer *X* maintains a group health plan with a plan year beginning October 1 and ending September 30. Individual *F* was hired by Employer *X* before the effective date of section 9802. Before the effective date of section 9802 for this plan (October 1, 1997), the terms of the plan allowed employees and their dependents to enroll when the employee was first hired, and on each January 1 thereafter, but in either case, only if the individual could pass a physical examination. *F*'s application to enroll when first hired was denied because *F* could not pass a physical examination. Upon the effective date of section 9802 for this plan (October 1, 1997), the plan is amended to delete the requirement to pass a physical examination. In November of 1997, the plan gives *F* an opportunity to enroll in the plan (including notice of the opportunity to enroll) without passing a physical examination, with coverage effective January 1, 1998.

(ii) *Conclusion.* In this *Example 1*, the plan complies with the requirements of this paragraph (i)(3)(ii).

Example 2. (i) *Facts.* The plan year of a group health plan begins January 1 and ends December 31. Under the plan, a dependent who is unable to engage in normal life activities on the date coverage would otherwise become effective is not enrolled until the dependent is able to engage in normal life activities. Individual *G* is a dependent who is otherwise eligible for coverage, but is unable to engage in normal life activities. The plan has not allowed *G* to enroll for coverage.

(ii) *Conclusion.* In this *Example 2*, beginning on the effective date of section 9802 for the plan (January 1, 1998), the plan provision is not permitted under any good faith interpretation of section 9802 or any guidance published by the Secretary. Therefore, the plan is required, not later than May 8, 2001, to give *G* an opportunity to enroll (including notice of the opportunity to enroll), with coverage effective, at *G*'s option, either retroactively from January 1, 1998 or prospectively from the date *G*'s request for enrollment is received by the plan. If *G* elects coverage to be effective beginning January 1, 1998, the plan can require *G* to pay employee premiums for the retroactive coverage.

(iii) *Individuals denied coverage based on a good faith interpretation of the law*—(A) *Opportunity to enroll required.* If a plan has denied coverage to any individual before the first day of the first plan year beginning on or after July 1, 2001 based in part on a health factor and that denial was based on a good faith interpretation of section 9802 or guidance published by the Secretary, the plan is required to give the individual an opportunity to enroll (including notice of an opportunity to enroll) that continues for at least 30 days, with coverage effective no later than July 1, 2001. Individuals required to be offered an opportunity to enroll include individuals previously offered enrollment without regard to a health factor but subsequently denied enrollment due to a health factor.

(B) *Relation to preexisting condition rules.* For purposes of Chapter 100 of Subtitle K, the individual may not be treated as a late enrollee or as a special enrollee. Moreover, the individual's enrollment date under the plan is the effective date for the plan described in section 401(c)(1) or (3) of the Health Insurance Portability and Accountability Act of 1996 (or, if the individual otherwise first became eligible to enroll for coverage after that date, on the date the individual was otherwise eligible to enroll in the plan). In

addition, any period between the individual's enrollment date and the effective date of coverage is treated as a waiting period.

(C) *Example.* The rules of this paragraph (i)(3)(iii) are illustrated by the following example:

Example. (i) *Facts.* Individual *H* was hired by Employer *Y* on May 3, 1995. *Y* maintains a group health plan with a plan year beginning on February 1. Under the terms of the plan, employees and their dependents are allowed to enroll when the employee is first hired (without a requirement to pass a physical examination), and on each February 1 thereafter if the individual can pass a physical examination. *H* chose not to enroll for coverage when hired in May of 1995. On February 1, 1997, *H* tried to enroll for coverage under the plan. However, *H* was denied coverage for failure to pass a physical examination. Shortly thereafter, *Y*'s plan eliminated late enrollment, and *H* was not given another opportunity to enroll in the plan. There is no evidence to suggest that *Y*'s plan was acting in bad faith in denying coverage under the plan beginning on the effective date of section 9802 (February 1, 1998).

(ii) *Conclusion.* In this *Example,* because coverage previously had been made available with respect to *H* without regard to any health factor of *H* and because *Y*'s plan was acting in accordance with a good faith interpretation of section 9802 (and guidance published by the Secretary), the failure of *Y*'s plan to allow *H* to enroll effective February 1, 1998 was permissible on that date. However, under the transitional rules of this paragraph (i)(3)(iii), *Y*'s plan must give *H* an opportunity to enroll that continues for at least 30 days, with coverage effective no later than July 1, 2001. (In addition, February 1, 1998 is *H*'s enrollment date under the plan and the period between February 1, 1998 and July 1, 2001 is treated as a waiting period. Accordingly, any preexisting condition exclusion period permitted under section 9801 will have expired before July 1, 2001.)

[T.D. 8931, 66 FR 1397, Jan. 8, 2001, as amended at 66 FR 14077, Mar. 9, 2001]

§ 54.9811–1T Standards relating to benefits for mothers and newborns (temporary).

(a) *Hospital length of stay*—(1) *General rule.* Except as provided in paragraph (a)(5) of this section, a group health plan that provides benefits for a hospital length of stay in connection with childbirth for a mother or her newborn may not restrict benefits for the stay to less than—

(i) 48 hours following a vaginal delivery; or

(ii) 96 hours following a delivery by cesarean section.

(2) *When stay begins*—(i) *Delivery in a hospital.* If delivery occurs in a hospital, the hospital length of stay for the mother or newborn child begins at the time of delivery (or in the case of multiple births, at the time of the last delivery).

(ii) *Delivery outside a hospital.* If delivery occurs outside a hospital, the hospital length of stay begins at the time the mother or newborn is admitted as a hospital inpatient in connection with childbirth. The determination of whether an admission is in connection with childbirth is a medical decision to be made by the attending provider.

(3) *Examples.* The rules of paragraphs (a)(1) and (2) of this section are illustrated by the following examples. In each example, the group health plan provides benefits for hospital lengths of stay in connection with childbirth and is subject to the requirements of this section, as follows:

Example 1. (i) A pregnant woman covered under a group health plan goes into labor and is admitted to the hospital at 10 p.m. on June 11. She gives birth by vaginal delivery at 6 a.m. on June 12.

(ii) In this *Example 1,* the 48-hour period described in paragraph (a)(1)(i) of this section ends at 6 a.m. on June 14.

Example 2. (i) A woman covered under a group health plan gives birth at home by vaginal delivery. After the delivery, the woman begins bleeding excessively in connection with the childbirth and is admitted to the hospital for treatment of the excessive bleeding at 7 p.m. on October 1.

(ii) In this *Example 2,* the 48-hour period described in paragraph (a)(1)(i) of this section ends at 7 p.m. on October 3.

Example 3. (i) A woman covered under a group health plan gives birth by vaginal delivery at home. The child later develops pneumonia and is admitted to the hospital. The attending provider determines that the admission is not in connection with childbirth.

(ii) In this *Example 3,* the hospital length-of-stay requirements of this section do not apply to the child's admission to the hospital because the admission is not in connection with childbirth.

(4) *Authorization not required*—(i) *In general.* A plan may not require that a physician or other health care provider obtain authorization from the plan, or

from a health insurance issuer offering health insurance coverage under the plan, for prescribing the hospital length of stay required under paragraph (a)(1) of this section. (See also paragraphs (b)(2) and (c)(3) of this section for rules and examples regarding other authorization and certain notice requirements.)

(ii) *Example.* The rule of this paragraph (a)(4) is illustrated by the following example:

Example. (i) In the case of a delivery by cesarean section, a group health plan subject to the requirements of this section automatically provides benefits for any hospital length of stay of up to 72 hours. For any longer stay, the plan requires an attending provider to complete a certificate of medical necessity. The plan then makes a determination, based on the certificate of medical necessity, whether a longer stay is medically necessary.

(ii) In this *Example,* the requirement that an attending provider complete a certificate of medical necessity to obtain authorization for the period between 72 hours and 96 hours following a delivery by cesarean section is prohibited by this paragraph (a)(4).

(5) *Exceptions*—(i) *Discharge of mother.* If a decision to discharge a mother earlier than the period specified in paragraph (a)(1) of this section is made by an attending provider, in consultation with the mother, the requirements of paragraph (a)(1) of this section do not apply for any period after the discharge.

(ii) *Discharge of newborn.* If a decision to discharge a newborn child earlier than the period specified in paragraph (a)(1) of this section is made by an attending provider, in consultation with the mother (or the newborn's authorized representative), the requirements of paragraph (a)(1) of this section do not apply for any period after the discharge.

(iii) *Attending provider defined.* For purposes of this section, *attending provider* means an individual who is licensed under applicable State law to provide maternity or pediatric care and who is directly responsible for providing maternity or pediatric care to a mother or newborn child.

(iv) *Example.* The rules of this paragraph (a)(5) are illustrated by the following example:

Example. (i) A pregnant woman covered under a group health plan subject to the requirements of this section goes into labor and is admitted to a hospital. She gives birth by cesarean section. On the third day after the delivery, the attending provider for the mother consults with the mother, and the attending provider for the newborn consults with the mother regarding the newborn. The attending providers authorize the early discharge of both the mother and the newborn. Both are discharged approximately 72 hours after the delivery. The plan pays for the 72-hour hospital stays.

(ii) In this *Example,* the requirements of this paragraph (a) have been satisfied with respect to the mother and the newborn. If either is readmitted, the hospital stay for the readmission is not subject to this section.

(b) *Prohibitions*—(1) *With respect to mothers*—(i) *In general.* A group health plan may not—

(A) Deny a mother or her newborn child eligibility or continued eligibility to enroll or renew coverage under the terms of the plan solely to avoid the requirements of this section; or

(B) Provide payments (including payments-in-kind) or rebates to a mother to encourage her to accept less than the minimum protections available under this section.

(ii) *Examples.* The rules of this paragraph (b)(1) are illustrated by the following examples. In each example, the group health plan is subject to the requirements of this section; as follows:

Example 1. (i) A group health plan provides benefits for at least a 48-hour hospital length of stay following a vaginal delivery. If a mother and newborn covered under the plan are discharged within 24 hours after the delivery, the plan will waive the copayment and deductible.

(ii) In this *Example 1,* because waiver of the copayment and deductible is in the nature of a rebate that the mother would not receive if she and her newborn remained in the hospital, it is prohibited by this paragraph (b)(1). (In addition, the plan violates paragraph (b)(2) of this section because, in effect, no copayment or deductible is required for the first portion of the stay and a double copayment and a deductible are required for the second portion of the stay.)

Example 2. (i) A group health plan provides benefits for at least a 48-hour hospital length of stay following a vaginal delivery. In the event that a mother and her newborn are discharged earlier than 48 hours and the discharges occur after consultation with the mother in accordance with the requirements of paragraph (a)(5) of this section, the plan

provides for a follow-up visit by a nurse within 48 hours after the discharges to provide certain services that the mother and her newborn would otherwise receive in the hospital.

(ii) In this *Example 2,* because the follow-up visit does not provide any services beyond what the mother and her newborn would receive in the hospital, coverage for the follow-up visit is not prohibited by this paragraph (b)(1).

(2) *With respect to benefit restrictions*—(i) *In general.* Subject to paragraph (c)(3) of this section, a group health plan may not restrict the benefits for any portion of a hospital length of stay required under paragraph (a) of this section in a manner that is less favorable than the benefits provided for any preceding portion of the stay.

(ii) *Example.* The rules of this paragraph (b)(2) are illustrated by the following example:

Example. (i) A group health plan subject to the requirements of this section provides benefits for hospital lengths of stay in connection with childbirth. In the case of a delivery by cesarean section, the plan automatically pays for the first 48 hours. With respect to each succeeding 24-hour period, the participant or beneficiary must call the plan to obtain precertification from a utilization reviewer, who determines if an additional 24-hour period is medically necessary. If this approval is not obtained, the plan will not provide benefits for any succeeding 24-hour period.

(ii) In this *Example,* the requirement to obtain precertification for the two 24-hour periods immediately following the initial 48-hour stay is prohibited by this paragraph (b)(2) because benefits for the latter part of the stay are restricted in a manner that is less favorable than benefits for a preceding portion of the stay. (However, this section does not prohibit a plan from requiring precertification for any period after the first 96 hours.) In addition, if the plan's utilization reviewer denied any mother or her newborn benefits within the 96-hour stay, the plan would also violate paragraph (a) of this section.

(3) *With respect to attending providers.* A group health plan may not directly or indirectly

(i) Penalize (for example, take disciplinary action against or retaliate against), or otherwise reduce or limit the compensation of, an attending provider because the provider furnished care to a participant or beneficiary in accordance with this section; or

(ii) Provide monetary or other incentives to an attending provider to induce the provider to furnish care to a participant or beneficiary in a manner inconsistent with this section, including providing any incentive that could induce an attending provider to discharge a mother or newborn earlier than 48 hours (or 96 hours) after delivery.

(c) *Construction.* With respect to this section, the following rules of construction apply:

(1) *Hospital stays not mandatory.* This section does not require a mother to—

(i) Give birth in a hospital; or

(ii) Stay in the hospital for a fixed period of time following the birth of her child.

(2) *Hospital stay benefits not mandated.* This section does not apply to any group health plan that does not provide benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn child.

(3) *Cost-sharing rules*—(i) *In general.* This section does not prevent a group health plan from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or a newborn under the plan or coverage, except that the coinsurance or other cost-sharing for any portion of the hospital length of stay required under paragraph (a) of this section may not be greater than that for any preceding portion of the stay.

(ii) *Examples.* The rules of this paragraph (c)(3) are illustrated by the following examples. In each example, the group health plan is subject to the requirements of this section, as follows:

Example 1. (i) A group health plan provides benefits for at least a 48-hour hospital length of stay in connection with vaginal deliveries. The plan covers 80 percent of the cost of the stay for the first 24-hour period and 50 percent of the cost of the stay for the second 24-hour period. Thus, the coinsurance paid by the patient increases from 20 percent to 50 percent after 24 hours.

(ii) In this *Example 1,* the plan violates the rules of this paragraph (c)(3) because coinsurance for the second 24-hour period of the 48-hour stay is greater than that for the preceding portion of the stay. (In addition, the plan also violates the similar rule in paragraph (b)(2) of this section.)

Example 2. (i) A group health plan generally covers 70 percent of the cost of a hospital length of stay in connection with childbirth. However, the plan will cover 80 percent of the cost of the stay if the participant or beneficiary notifies the plan of the pregnancy in advance of admission and uses whatever hospital the plan may designate.

(ii) In this *Example 2,* the plan does not violate the rules of this paragraph (c)(3) because the level of benefits provided (70 percent or 80 percent) is consistent throughout the 48-hour (or 96-hour) hospital length of stay required under paragraph (a) of this section. (In addition, the plan does not violate the rules in paragraph (a)(4) or (b)(2) of this section.)

(4) *Compensation of attending provider.* This section does not prevent a group health plan from negotiating with an attending provider the level and type of compensation for care furnished in accordance with this section (including paragraph (b) of this section).

(d) *Notice requirement.* See 29 CFR 2520.102–3(u) and (v)(2) for rules relating to a notice requirement imposed under section 711 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181) on certain group health plans that provide benefits for hospital lengths of stay in connection with childbirth.

(e) *Applicability in certain States*—(1) *Health insurance coverage.* The requirements of section 9811 and this section do not apply with respect to health insurance coverage offered in connection with a group health plan if there is a State law regulating the coverage that meets any of the following criteria:

(i) The State law requires the coverage to provide for at least a 48-hour hospital length of stay following a vaginal delivery and at least a 96-hour hospital length of stay following a delivery by cesarean section.

(ii) The State law requires the coverage to provide for maternity and pediatric care in accordance with guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or any other established professional medical association.

(iii) The State law requires, in connection with the coverage for maternity care, that the hospital length of stay for such care is left to the decision of (or is required to be made by) the attending provider in consultation with the mother. State laws that require the decision to be made by the attending provider with the consent of the mother satisfy the criterion of this paragraph (e)(1)(iii).

(2) *Group health plans*—(i) *Fully-insured plans.* For a group health plan that provides benefits solely through health insurance coverage, if the State law regulating the health insurance coverage meets any of the criteria in paragraph (e)(1) of this section, then the requirements of section 9811 and this section do not apply.

(ii) *Self-insured plans.* For a group health plan that provides all benefits for hospital lengths of stay in connection with childbirth other than through health insurance coverage, the requirements of section 9811 and this section apply.

(iii) *Partially-insured plans.* For a group health plan that provides some benefits through health insurance coverage, if the State law regulating the health insurance coverage meets any of the criteria in paragraph (e)(1) of this section, then the requirements of section 9811 and this section apply only to the extent the plan provides benefits for hospital lengths of stay in connection with childbirth other than through health insurance coverage.

(3) *Preemption provisions under ERISA.* See 29 CFR 2590.711(e)(3) regarding how rules parallel to those under paragraph (e)(1) of this section relate to other preemption provisions under the Employee Retirement Income Security Act of 1974.

(4) *Examples.* The rules of this paragraph (e) are illustrated by the following examples:

Example 1. (i) A group health plan buys group health insurance coverage in a State that requires that the coverage provide for at least a 48-hour hospital length of stay following a vaginal delivery and at least a 96-hour hospital length of stay following a delivery by cesarean section.

(ii) In this *Example 1,* the coverage is subject to State law, and the requirements of section 9811 and this section do not apply.

Example 2. (i) A self-insured group health plan covers hospital lengths of stay in connection with childbirth in a State that requires health insurance coverage to provide for maternity care in accordance with guidelines established by the American College of Obstetricians and Gynecologists and to provide for pediatric care in accordance with

guidelines established by the American Academy of Pediatrics.

(ii) In this *Example 2*, even though the State law satisfies the criterion of paragraph (e)(1)(ii) of this section, because the plan provides benefits for hospital lengths of stay in connection with childbirth other than through health insurance coverage, the plan is subject to the requirements of section 9811 and this section.

(f) *Effective date.* Section 9811 applies to group health plans for plan years beginning on or after January 1, 1998. This section applies to group health plans for plan years beginning on or after January 1, 1999.

[T.D. 8788, 63 FR 57554, Oct. 27, 1998]

§ 54.9812–1T Parity in the application of certain limits to mental health benefits (temporary).

(a) *Definitions.* For purposes of this section, except where the context clearly indicates otherwise, the following definitions apply:

Aggregate lifetime limit means a dollar limitation on the total amount of specified benefits that may be paid under a group health plan for an individual (or for a group of individuals considered a single unit in applying this dollar limitation, such as a family or an employee plus spouse).

Annual limit means a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a plan for an individual (or for a group of individuals considered a single unit in applying this dollar limitation, such as a family or an employee plus spouse).

Medical/surgical benefits means benefits for medical or surgical services, as defined under the terms of the plan, but does not include mental health benefits.

Mental health benefits means benefits for mental health services, as defined under the terms of the plan, but does not include benefits for treatment of substance abuse or chemical dependency.

(b) *Requirements regarding limits on benefits*—(1) *In general*—(i) *General parity requirement.* A group health plan that provides both medical/surgical benefits and mental health benefits must comply with paragraph (b) (2), (3), or (6) of this section.

(ii) Exception. The rule in paragraph (b)(1)(i) of this section does not apply if a plan satisfies the requirements of paragraph (e) or (f) of this section.

(2) *Plan with no limit or limits on less than one-third of all medical/surgical benefits.* If a plan does not include an aggregate lifetime or annual limit on any medical/surgical benefits or includes aggregate lifetime or annual limits that apply to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual limit, respectively, on mental health benefits.

(3) *Plan with a limit on at least two-thirds of all medical/surgical benefits.* If a plan includes an aggregate lifetime or annual limit on at least two-thirds of all medical/surgical benefits, it must either—

(i) Apply the aggregate lifetime or annual limit both to the medical/surgical benefits to which the limit would otherwise apply and to mental health benefits in a manner that does not distinguish between the medical/surgical and mental health benefits; or

(ii) Not include an aggregate lifetime or annual limit on mental health benefits that is less than the aggregate lifetime or annual limit, respectively, on the medical/surgical benefits.

(4) *Examples.* The rules of paragraphs (b)(2) and (3) of this section are illustrated by the following examples:

Example 1. (i) Prior to the effective date of the mental health parity provisions, a group health plan had no annual limit on medical/surgical benefits and had a $10,000 annual limit on mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Eliminating the plan's annual limit on mental health benefits;

(B) Replacing the plan's previous annual limit on mental health benefits with a $500,000 annual limit on all benefits (including medical/surgical and mental health benefits); and

(C) Replacing the plan's previous annual limit on mental health benefits with a $250,000 annual limit on medical/surgical benefits and a $250,000 annual limit on mental health benefits.

(ii) In this *Example 1*, each of the three options being considered by the plan sponsor would comply with the requirements of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

Example 2. (i) Prior to the effective date of the mental health parity provisions, a group health plan had a $100,000 annual limit on medical/surgical inpatient benefits, a $50,000 annual limit on medical/surgical outpatient benefits, and a $100,000 annual limit on all mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Replacing the plan's previous annual limit on mental health benefits with a $150,000 annual limit on mental health benefits; and

(B) Replacing the plan's previous annual limit on mental health benefits with a $100,000 annual limit on mental health inpatient benefits and a $50,000 annual limit on mental health outpatient benefits.

(ii) In this *Example 2*, each option under consideration by the plan sponsor would comply with the requirements of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

Example 3. (i) A group health plan that is subject to the requirements of this section has no aggregate lifetime or annual limit for either medical/surgical benefits or mental health benefits. While the plan provides medical/surgical benefits with respect to both network and out-of-network providers, it does not provide mental health benefits with respect to out-of-network providers.

(ii) In this *Example 3*, the plan complies with the requirements of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

Example 4. (i) Prior to the effective date of the mental health parity provisions, a group health plan had an annual limit on medical/surgical benefits and a separate but identical annual limit on mental health benefits. The plan included benefits for treatment of substance abuse and chemical dependency in its definition of mental health benefits. Accordingly, claims paid for treatment of substance abuse and chemical dependency were counted in applying the annual limit on mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Making no change in the plan so that claims paid for treatment of substance abuse and chemical dependency continue to count in applying the annual limit on mental health benefits;

(B) Amending the plan to count claims paid for treatment of substance abuse and chemical dependency in applying the annual limit on medical/surgical benefits (rather than counting those claims in applying the annual limit on mental health benefits);

(C) Amending the plan to provide a new category of benefits for treatment of chemical dependency and substance abuse that is subject to a separate, lower limit and under which claims paid for treatment of substance abuse and chemical dependency are counted only in applying the annual limit on this separate category; and

(D) Amending the plan to eliminate distinctions between medical/surgical benefits and mental health benefits and establishing an overall limit on benefits offered under the plan under which claims paid for treatment of substance abuse and chemical dependency are counted with medical/surgical benefits and mental health benefits in applying the overall limit.

(ii) In this *Example 4*, the group health plan is described in paragraph (b)(3) of this section. Because mental health benefits are defined in paragraph (a) of this section as excluding benefits for treatment of substance abuse and chemical dependency, the inclusion of benefits for treatment of substance abuse and chemical dependency in applying an aggregate lifetime limit or annual limit on mental health benefits under option (A) of this *Example 4* would not comply with the requirements of paragraph (b)(3) of this section. However, options (B), (C), and (D) of this *Example 4*. Would comply with the requirements of paragraph (b)(3) of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

(5) *Determining one-third and two-thirds of all medical/surgical benefits.* For purposes of this paragraph (b), the determination of whether the portion of medical/surgical benefits subject to a limit represents one-third or two-thirds of all medical/surgical benefits is based on the dollar amount of all plan payments for medical/surgical benefits expected to be paid under the plan for the plan year (or for the portion of the plan year after a change in plan benefits that affects the applicability of the aggregate lifetime or annual limits). Any reasonable method may be used to determine whether the dollar amounts expected to be paid under the plan will constitute one-third or two-thirds of the dollar amount of all plan payments for medical/surgical benefits.

(6) *Plan not described in paragraph (b)(2) or (3) of this section*—(i) *In general.* A group health plan that is not described in paragraph (b)(2) or (3) of this section, must either—

(A) Impose no aggregate lifetime or annual limit, as appropriate, on mental health benefits; or

(B) Impose an aggregate lifetime or annual limit on mental health benefits that is no less than an average limit for medical/surgical benefits calculated in the following manner. The average limit is calculated by taking into account the weighted average of the aggregate lifetime or annual limits, as appropriate, that are applicable to the categories of medical/surgical benefits. Limits based on delivery systems, such as inpatient/outpatient treatment or normal treatment of common, low-cost conditions (such as treatment of normal births), do not constitute categories for purposes of this paragraph (b)(6)(i)(B). In addition, for purposes of determining weighted averages, any benefits that are not within a category that is subject to a separately-designated limit under the plan are taken into account as a single separate category by using an estimate of the upper limit on the dollar amount that a plan may reasonably be expected to incur with respect to such benefits, taking into account any other applicable restrictions under the plan.

(ii) *Weighting.* For purposes of this paragraph (b)(6), the weighting applicable to any category of medical/surgical benefits is determined in the manner set forth in paragraph (b)(5) of this section for determining one-third or two-thirds of all medical/surgical benefits.

(iii) *Example.* The rules of this paragraph (b)(6) are illustrated by the following example:

Example. (i) A group health plan that is subject to the requirements of this section includes a $100,000 annual limit on medical/surgical benefits related to cardio-pulmonary diseases. The plan does not include an annual limit on any other category of medical/surgical benefits. The plan determines that 40% of the dollar amount of plan payments for medical/surgical benefits are related to cardio-pulmonary diseases. The plan determines that $1,000,000 is a reasonable estimate of the upper limit on the dollar amount that the plan may incur with respect to the other 60% of payments for medical/surgical benefits.

(ii) In this *Example,* the plan is not described in paragraph (b)(3) of this section because there is not one annual limit that applies to at least two-thirds of all medical/surgical benefits. Further, the plan is not described in paragraph (b)(2) of this section because more than one-third of all medical/surgical benefits are subject to an annual limit. Under this paragraph (b)(6), the plan sponsor can choose either to include no annual limit on mental health benefits, or to include an annual limit on mental health benefits that is not less than the weighted average of the annual limits applicable to each category of medical/surgical benefits. In this example, the minimum weighted average annual limit that can be applied to mental health benefits is $640,000 (40% x $100,000 + 60% x $1,000,000 = $640,000).

(c) *Rule in the case of separate benefit packages.* If a group health plan offers two or more benefit packages, the requirements of this section, including the exemption provisions in paragraph (f) of this section, apply separately to each benefit package. Examples of a group health plan that offers two or more benefit packages include a group health plan that offers employees a choice between indemnity coverage or HMO coverage, and a group health plan that provides one benefit package for retirees and a different benefit package for current employees.

(d) *Applicability*—(1) *Group health plans.* The requirements of this section apply to a group health plan offering both medical/surgical benefits and mental health benefits regardless of whether the mental health benefits are administered separately under the plan.

(2) *Health insurance issuers.* See 29 CFR 2590.712(d)(2) and 45 CFR 146.136(d)(2), which provide that health insurance issuers offering health insurance coverage for both medical/surgical benefits and mental health benefits in connection with a group health plan are subject to rules similar to those applicable to group health plans under this section.

(3) *Scope.* This section does not—

(i) Require a group health plan to provide any mental health benefits; or

(ii) Affect the terms and conditions (including cost sharing, limits on the number of visits or days of coverage, requirements relating to medical necessity, requiring prior authorization for treatment, or requiring primary care physicians' referrals for treatment) relating to the amount, duration, or scope of the mental health benefits under the plan except as specifically provided in paragraph (b) of this section.

(e) *Small employer exemption*—(1) *In general.* The requirements of this section do not apply to a group health plan for a plan year of a small employer. For purposes of this paragraph (e), the term *small employer* means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least two but not more than 50 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year. See section 9831(a) and §54.9831–1T(a), which provide that this section (and certain other sections) does not apply to any group health plan for any plan year if, on the first day of the plan year, the plan has fewer than two participants who are current employees.

(2) *Rules in determining employer size.* For purposes of paragraph (e)(1) of this section—

(i) All persons treated as a single employer under subsections (b), (c), (m), and (o) of section 414 are treated as one employer;

(ii) If an employer was not in existence throughout the preceding calendar year, whether it is a small employer is determined based on the average number of employees the employer reasonably expects to employ on business days during the current calendar year; and

(iii) Any reference to an employer for purposes of the small employer exemption includes a reference to a predecessor of the employer.

(f) *Increased cost exemption*—(1) *In general.* A group health plan is not subject to the requirements of this section if the requirements of this paragraph (f) are satisfied. If a plan offers more than one benefit package, this paragraph (f) applies separately to each benefit package. Except as provided in paragraph (h) of this section, a plan must comply with the requirements of paragraph (b)(1)(i) of this section for the first plan year beginning on or after January 1, 1998, and must continue to comply with the requirements of paragraph (b)(1)(i) of this section until the plan satisfies the requirements in this paragraph (f). In no event is the exemption of this paragraph (f) effective until 30 days after the notice requirements in paragraph (f)(3) of this section are satisfied. If the requirements of this paragraph (f) are satisfied with respect to a plan, the exemption continues in effect (at the plan's discretion) until September 30, 2001, even if the plan subsequently purchases a different policy from the same or a different issuer and regardless of any other changes to the plan's benefit structure.

(2) *Calculation of the one-percent increase*—(i) *Ratio.* A group health plan satisfies the requirements of this paragraph (f)(2) if the application of paragraph (b)(1)(i) of this section to the plan results in an increase in the cost under the plan of at least one percent. The application of paragraph (b)(1)(i) of this section results in an increased cost of at least one percent under a group health plan only if the ratio below equals or exceeds 1.01000. The ratio is determined as follows:

(A) The incurred expenditures during the base period, divided by,

(B) The incurred expenditures during the base period, reduced by——

(*1*) The claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section; and

(*2*) Administrative expenses attributable to complying with the requirements of this section.

(ii) *Formula.* The ratio of paragraph (f)(2)(i) of this section is expressed mathematically as follows:

$$\frac{IE}{IE-(CE+AE)} \geq 1.01000$$

(A) *IE* means the incurred expenditures during the base period.

(B) *CE* means the claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section.

(C) *AE* means administrative costs related to claims in *CE* and other administrative costs attributable to complying with the requirements of this section.

(iii) *Incurred expenditures. Incurred expenditures* means actual claims incurred during the base period and reported within two months following the base period, and administrative

costs for all benefits under the group health plan, including mental health benefits and medical/surgical benefits, during the base period. Incurred expenditures do not include premiums.

(iv) *Base period.* *Base period* means the period used to calculate whether the plan may claim the one-percent increased cost exemption in this paragraph (f). The base period must begin on the first day in any plan year that the plan complies with the requirements of paragraph (b)(1)(i) of this section and must extend for a period of at least six consecutive calendar months. However, in no event may the base period begin prior to September 26, 1996 (the date of enactment of the Mental Health Parity Act (Pub. L. 104–204, 110 Stat. 2944)).

(v) *Rating pools.* For plans that are combined in a pool for rating purposes, the calculation under this paragraph (f)(2) for each plan in the pool for the base period is based on the incurred expenditures of the pool, whether or not all the plans in the pool have participated in the pool for the entire base period. (However, only the plans that have complied with paragraph (b)(1)(i) of this section for at least six months as a member of the pool satisfy the requirements of this paragraph (f)(2).) Otherwise, the calculation under this paragraph (f)(2) for each plan is calculated by the plan administrator based on the incurred expenditures of the plan.

(vi) *Examples.* The rules of this paragraph (f)(2) are illustrated by the following examples:

Example 1. (i) A group health plan has a plan year that is the calendar year. The plan satisfies the requirements of paragraph (b)(1)(i) of this section as of January 1, 1998. On September 15, 1998, the plan determines that $1,000,000 in claims have been incurred during the period between January 1, 1998 and June 30, 1998 and reported by August 30, 1998. The plan also determines that $100,000 in administrative costs have been incurred for all benefits under the group health plan, including mental health benefits. Thus, the plan determines that its incurred expenditures for the base period are $1,100,000. The plan also determines that the claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section are $40,000 and that administrative expenses attributable to complying with the requirements of this section are $10,000. Thus, the total amount of expenditures for the base period had the plan not been amended to comply with the requirements of paragraph (b)(1)(i) of this section are $1,050,000 ($1,100,000—($40,000 + $10,000) = $1,050,000).

(ii) In this *Example 1*, the plan satisfies the requirements of this paragraph (f)(2) because the application of this section results in an increased cost of at least one percent under the terms of the plan ($1,100,000/$1,050,000 = 1.04762).

Example 2. (i) A health insurance issuer sells a group health insurance policy that is rated on a pooled basis and is sold to 30 group health plans. One of the group health plans inquires whether it qualifies for the one-percent increased cost exemption. The issuer performs the calculation for the pool as a whole and determines that the application of this section results in an increased cost of 0.500 percent (for a ratio under this paragraph (f)(2) of 1.00500) for the pool. The issuer informs the requesting plan and the other plans in the pool of the calculation.

(ii) In this *Example 2*, none of the plans satisfy the requirements of this paragraph (f)(2) and a plan that purchases a policy not complying with the requirements of paragraph (b)(1)(i) of this section violates the requirements of this section.

Example 3. (i) A partially insured plan is collecting the information to determine whether it qualifies for the exemption. The plan administrator determines the incurred expenses for the base period for the self-funded portion of the plan to be $2,000,000 and the administrative expenses for the base period for the self-funded portion to be $200,000. For the insured portion of the plan, the plan administrator requests data from the insurer. For the insured portion of the plan, the plan's own incurred expenses for the base period are $1,000,000 and the administrative expenses for the base period are $100,000. The plan administrator determines that under the self-funded portion of the plan, the claims incurred for the base period that would have been denied under the terms of the plan absent the amendment are $0 because the self-funded portion does not cover mental health benefits and the plan's administrative costs attributable to complying with the requirements of this section are $1,000. The issuer determines that under the insured portion of the plan, the claims incurred for the base period that would have been denied under the terms of the plan absent the amendment are $25,000 and the administrative costs attributable to complying with the requirements of this section are $1,000. Thus, the total incurred expenditures for the plan for the base period are $3,300,000 ($2,000,000 + $200,000 + $1,000,000 + $100,000 = $3,300,000) and the total amount of expenditures for the base period had the plan not

been amended to comply with the requirements of paragraph (b)(1)(i) of this section are $3,273,000 ($3,300,000 − ($0 + $1,000 + $25,000 + $1,000) = $3,273,000).

(ii) In this *Example 3,* the plan does not satisfy the requirements of this paragraph (f)(2) because the application of this section does not result in an increased cost of at least one percent under the terms of the plan ($3,300,000/$3,273,000 = 1.00825).

(3) *Notice of exemption*—(i) *Participants and beneficiaries*—(A) *In general.* A group health plan must notify participants and beneficiaries of the plan's decision to claim the one-percent increased cost exemption. The notice must include the following information:

(*1*) A statement that the plan is exempt from the requirements of this section and a description of the basis for the exemption;

(*2*) The name and telephone number of the individual to contact for further information;

(*3*) The plan name and plan number (PN);

(*4*) The plan administrator's name, address, and telephone number;

(*5*) For single-employer plans, the plan sponsor's name, address, and telephone number (if different from paragraph (f)(3)(i)(A)(*3*) of this section) and the plan sponsor's employer identification number (EIN);

(*6*) The effective date of the exemption;

(*7*) The ability of participants and beneficiaries to contact the plan administrator to see how benefits may be affected as a result of the plan's claim of the exemption; and

(*8*) The availability, upon request and free of charge, of a summary of the information required under paragraph (f)(4) of this section.

(B) *Use of summary of material reductions in covered services or benefits.* A plan may satisfy the requirements of paragraph (f)(3)(i)(A) of this section by providing participants and beneficiaries (in accordance with paragraph (f)(3)(i)(C) of this section) with a summary of material reductions in covered services or benefits required under 29 CFR 2520.104b–3(d) that also includes the information of this paragraph (f)(3)(i). However, in all cases, the exemption is not effective until 30 days after notice has been sent.

(C) *Delivery.* The notice described in this paragraph (f)(3)(i) is required to be provided to all participants and beneficiaries. The notice may be furnished by any method of delivery that satisfies the requirements of section 104(b)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1024(b)(1)) (e.g., first-class mail). If the notice is provided to the participant at the participant's last known address, then the requirements of this paragraph (f)(3)(i) are satisfied with respect to the participant and all beneficiaries residing at that address. If a beneficiary's last known address is different from the participant's last known address, a separate notice is required to be provided to the beneficiary at the beneficiary's last known address.

(D) *Example.* The rules of this paragraph (f)(3)(i) are illustrated by the following example:

Example. (i) A group health plan has a plan year that is the calendar year and has an open enrollment period every November 1 through November 30. The plan determines on September 15 that it satisfies the requirements of paragraph (f)(2) of this section. As part of its open enrollment materials, the plan mails, on October 15, to all participants and beneficiaries a notice satisfying the requirements of this paragraph (f)(3)(i).

(ii) In this *Example,* the plan has sent the notice in a manner that complies with this paragraph (f)(3)(i).

(ii) *Federal agencies.* A group health plan that is a church plan (as defined in section 414(e)) claiming the exemption of this paragraph (f) for any benefit package must provide notice in accordance with the requirement of this paragraph (f)(3)(ii). This requirement is satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (f)(3)(i) of this section identifying the benefit package to which the exemption applies. For any other group health plan, see 29 CFR 2590.712(f)(3)(ii)(B).

(4) *Availability of documentation.* The plan must make available to participants and beneficiaries (or their representatives), on request and at no charge, a summary of the information on which the exemption was based. An individual who is not a participant or beneficiary and who presents a notice

described in paragraph (f)(3)(i) of this section is considered to be a representative. A representative may request the summary of information by providing the plan a copy of the notice provided to the participant under paragraph (f)(3)(i) of this section with any individually identifiable information redacted. The summary of information must include the incurred expenditures, the base period, the dollar amount of claims incurred during the base period that would have been denied under the terms of the plan absent amendments required to comply with paragraph (b)(1)(i) of this section, the administrative costs related to those claims, and other administrative costs attributable to complying with the requirements of this section. In no event should the summary of information include any individually identifiable information.

(g) *Special rules for group health insurance coverage*—(1) *Sale of nonparity policies.* See 29 CFR 2590.712(g)(1) and 45 CFR 146.136(g)(1) for rules limiting the right of an issuer to sell a policy without parity (as described in 29 CFR 2590.712(b) and 45 CFR 146.136(b)) to a plan that meets the requirements of 29 CFR 2590.712 (e) or (f) and 45 CFR 146.136 (e) or (f)).

(2) *Duration of exemption.* After a plan meets the requirements of paragraph (f) of this section, the plan may change issuers without having to meet the requirements of paragraph (f) of this section again before September 30, 2001.

(h) *Effective dates*—(1) *In general.* The requirements of this section are applicable for plan years beginning on or after January 1, 1998.

(2) *Limitation on actions.* (i) Except as provided in paragraph (h)(3) of this section, no enforcement action is to be taken by the Secretary against a group health plan that has sought to comply in good faith with the requirements of section 9812, with respect to a violation that occurs before the earlier of—

(A) The first day of the first plan year beginning on or after April 1, 1998; or

(B) January 1, 1999.

(ii) Compliance with the requirements of this section is deemed to be good faith compliance with the requirements of section 9812.

(iii) The rules of this paragraph (h)(2) are illustrated by the following examples:

Example 1. (i) A group health plan has a plan year that is the calendar year. The plan complies with section 9812 in good faith using assumptions inconsistent with paragraph (b)(6) of this section relating to weighted averages for categories of benefits.

(ii) In this *Example 1*, no enforcement action may be taken against the plan with respect to a violation resulting solely from those assumptions and occurring before January 1, 1999.

Example 2. (i) A group health plan has a plan year that is the calendar year. For the entire 1998 plan year, the plan applies a $1,000,000 annual limit on medical/surgical benefits and a $100,000 annual limit on mental health benefits.

(ii) In this *Example 2*, the plan has not sought to comply with the requirements of section 9812 in good faith, and this paragraph (h)(2) does not apply.

(3) *Transition period for increased cost exemption*—(i) *In general.* No enforcement action will be taken against a group health plan that is subject to the requirements of this section based on a violation of this section that occurs before April 1, 1998 solely because the plan claims the increased cost exemption under section 9812(c)(2) based on assumptions inconsistent with the rules under paragraph (f) of this section, provided that a plan amendment that complies with the requirements of paragraph (b)(1)(i) of this section is adopted and effective no later than March 31, 1998 and the plan complies with the notice requirements in paragraph (h)(3)(ii) of this section.

(ii) *Notice of plan's use of transition period.* (A) A group health plan satisfies the requirements of this paragraph (h)(3)(ii) only if the plan provides notice to the applicable federal agency and posts the notice at the location(s) where documents must be made available for examination by participants and beneficiaries under section 104(b)(2) of the Employee Retirement Income Security Act of 1974, and the regulations thereunder (29 CFR 2520.104b–1(b)(3)). The notice must indicate the plan's decision to use the transition period in paragraph (h)(3)(i) of this section by 30 days after the first day of the plan year beginning on or after January 1, 1998, but in no event later than March 31, 1998. For a group health

plan that is a church plan (as defined in section 414(e)), the applicable federal agency is the Department of the Treasury. For a group health plan that is not a church plan, see 29 CFR 2590.712(h)(3)(ii). The notice must include—

(*1*) The name of the plan and the plan number (PN);

(*2*) The name, address, and telephone number of the plan administrator;

(*3*) For single-employer plans, the name, address, and telephone number of the plan sponsor (if different from the plan administrator) and the plan sponsor's employer identification number (EIN);

(*4*) The name and telephone number of the individual to contact for further information; and

(*5*) The signature of the plan administrator and the date of the signature.

(B) The notice must be provided at no charge to participants or their representative within 15 days after receipt of a written or oral request for such notification, but in no event before the notice has been sent to the applicable federal agency.

(i) *Sunset.* This section does not apply to benefits for services furnished on or after September 30, 2001.

[T.D. 8741, 62 FR 66953, Dec. 22, 1997]

§ 54.9831–1T Special rules relating to group health plans (temporary).

(a) *General exception for certain small group health plans.* The requirements of Chapter 100 of Subtitle K of the Internal Revenue Code do not apply to any group health plan for any plan year if, on the first day of the plan year, the plan has fewer than 2 participants who are current employees.

(b) *Excepted benefits*—(1) *In general.* The requirements of §§ 54.9801–1T through 54.9801–6T, 54.9802–1T, 54.9811–1T, and 54.9812–1T do not apply to any group health plan in relation to its provision of the benefits described in paragraph (b)(2), (3), (4), or (5) of this section (or any combination of these benefits).

(2) *Benefits excepted in all circumstances.* The following benefits are excepted in all circumstances—

(i) Coverage only for accident (including accidental death and dismemberment);

(ii) Disability income insurance;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Coverage issued as a supplement to liability insurance;

(v) Workers' compensation or similar insurance;

(vi) Automobile medical payment insurance;

(vii) Credit-only insurance (for example, mortgage insurance); and

(viii) Coverage for on-site medical clinics.

(3) *Limited excepted benefits*—

(i) *In general.* Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the plan, as defined in paragraph (b)(3)(ii) of this section.

(ii) *Integral.* For purposes of paragraph (b)(3)(i) of this section, benefits are deemed to be an integral part of a plan unless a participant has the right to elect not to receive coverage for the benefits and, if the participant elects to receive coverage for the benefits, the participant pays an additional premium or contribution for that coverage.

(iii) *Limited scope.* Limited scope dental or vision benefits are dental or vision benefits that are sold under a separate policy or rider and that are limited in scope in a narrow range or type of benefits that are generally excluded from hospital/medical/surgical benefit packages.

(iv) *Long-term care.* Long-term care benefits are benefits that are either—

(A) Subject to State long-term care insurance laws;

(B) For qualified long-term care insurance services, as defined in section 7702B(c)(1) of the Internal Revenue Code, or provided under a qualified long-term care insurance contract, as defined in section 7702B(b); or

(C) Based on cognitive impairment or a loss of functional capacity that is expected to be chronic.

(4) *Noncoordinated benefits*—(i) *Excepted benefits that are not coordinated.* Coverage for only a specified disease or illness (for example, cancer-only policies) or hospital indemnity or other

fixed dollar indemnity insurance (for example, $100/day) is excepted only if it meets each of the conditions specified in paragraph (b)(4)(ii) of this section.

(ii) *Conditions.* Benefits are described in paragraph (b)(4)(i) of this section only if—

(A) The benefits are provided under a separate policy, certificate, or contract of insurance;

(B) There is no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor; and

(C) The benefits are paid with respect to an event without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor.

(5) *Supplemental benefits.* The following benefits are excepted only if they are provided under a separate policy, certificate, or contract of insurance—

(i) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act; also known as Medigap or MedSupp insurance);

(ii) Coverage supplemental to the coverage provided under Chapter 55, Title 10 of the United States Code (also known as CHAMPUS supplemental programs); and

(iii) Similar supplemental coverage provided to coverage under a group health plan.

(c) *Treatment of partnerships.* [Reserved]

[T.D. 8716, 62 FR 16939, Apr. 8, 1997; 62 FR 31670, June 10, 1997. Redesignated and amended by T.D. 8741, 62 FR 66952, Dec. 22, 1997; T.D. 8788, 63 FR 57556, Oct. 27, 1998]

§ 54.9833–1T Effective dates (temporary).

(a) *General effective dates*—(1) *Non-collectively-bargained plans.* Except as otherwise provided in this section, Chapter 100 of Subtitle K and §§ 54.9801–1T through 54.9806–1T, 54.9802–1T, and 54.9831–1T apply with respect to group health plans for plan years beginning after June 30, 1997.

(2) *Collectively bargained plans.* Except as otherwise provided in this section (other than paragraph (a)(1) of this section), in the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before August 21, 1996, Chapter 100 of Subtitle K and §§ 54.9801–1T through 54.9801–6T, 54.9802–1T, and 54.9831–1T do not apply to plan years beginning before the later of July 1, 1997, or the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after August 21, 1996). For these purposes, any plan amendment made pursuant to a collective bargaining agreement relating to the plan, that amends the plan solely to conform to any requirement of such Chapter, is not treated as a termination of the collective bargaining agreement.

(3)(i) *Preexisting condition exclusion periods for current employees.* Any preexisting condition exclusion period permitted under § 54.9801–3T is measured from the individual's enrollment date in the plan. Such exclusion period, as limited under § 54.9801–3T, may be completed prior to the effective date of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for his or her plan. Therefore, on the date the individual's plan becomes subject to Chapter 100 of Subtitle K of the Internal Revenue Code, no preexisting condition exclusion may be imposed with respect to an individual beyond the limitation in § 54.9801–3T. For an individual who has not completed the permitted exclusion period under HIPAPA, upon the effective date for his or her plan, the individual may use creditable coverage that the individual had prior to the enrollment date to reduce the remaining preexisting condition exclusion period applicable to the individual.

(ii) *Examples.* The following examples illustrate the rules of this paragraph (a)(3):

Example 1. (i) Individual *A* has been working for Employer *X* and has been covered under Employer *X*'s plan since March 1, 1997. Under Employer *X*'s plan, as in effect before January 1, 1998, there is no coverage for any preexisting condition. Employer *X*'s plan year begins on January 1, 1998. *A*'s enrollment date in the plan is March 1, 1997 and *A* has no creditable coverage before this date.

(ii) In this *Example 1*, Employer *X* may continue to impose the preexisting condition exclusion under the plan through February 28, 1998 (the end of the 12-month period using anniversary dates).

Example 2. (i) Same facts as in *Example 1*, except that *A*'s enrollment date was August 1, 1996, instead of March 1, 1997.

(ii) In this *Example 2*, on January 1, 1998, Employer *X*'s plan may no longer exclude treatment for any preexisting condition that *A* may have; however, because Employer *X*'s plan is not subject to HIPAA until January 1, 1998, *A* is not entitled to claim reimbursement for expenses under the plan for treatments for any preexisting condition of *A* received before January 1, 1998.

(b) *Effective date for certification requirement*—(1) *In general.* Subject to the transitional rule in §54.9801–5T(a)(5)(iii), the certification rules of §54.9801–5T apply to events occurring on or after July 1, 1996.

(2) *Period covered by certificate.* A certificate is not required to reflect coverage before July 1, 1996.

(3) *No certificate before June 1, 1997.* Notwithstanding any other provision of §54.9801–5T, in no case is a certificate required to be provided before June 1, 1997.

(c) *Limitation on actions.* No enforcement action is to be taken, pursuant to Chapter 100 of Subtitle K of the Internal Revenue Code, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by Chapter 100 of Subtitle K of the Internal Revenue Code before January 1, 1998 if the plan or issuer has sought to comply in good faith with such requirements. Compliance with these regulations is deemed to be good faith compliance with the requirements of Chapter 100 of Subtitle K.

(d) *Transition rules for counting creditable coverage.* An individual who seeks to establish creditable coverage for periods before July 1, 1996 is entitled to establish such coverage through the presentation of documents or other means in accordance with the provisions of §54.9801–5T(c). For coverage relating to an event occurring before July 1, 1996, a group health plan and a health insurance issuer are not subject to any penalty or enforcement action with respect to the plan's or issuer's counting (or not counting) such coverage if the plan or issuer has sought to comply in good faith with the applicable requirements under §54.9801–5T(c).

(e) *Transition rules for certificates of creditable coverage*—(1) *Certificates only upon request.* For events occurring on or after July 1, 1996 but before October 1, 1996, a certificate is required to be provided only upon a written request by or on behalf of the individual to whom the certificate applies.

(2) *Certificates before June 1, 1997.* For events occurring on or after October 1, 1996 and before June 1, 1997, a certificate must be furnished no later than June 1, 1997, or any later date permitted under §54.9801–5T(a)(2) (ii) and (iii).

(3) *Optional notice*—(i) *In general.* This paragraph (e)(3) applies with respect to events described in §54.9801–5T(a)(2)(ii), that occur on or after October 1, 1996 but before June 1, 1997. A group health plan or health insurance issuer offering group health coverage is deemed to satisfy §54.9801–5T(a) (2) and (3) if a notice is provided in accordance with the provisions of paragraphs (e)(3) (i) through (iv) of this section.

(ii) *Time of notice.* The notice must be provided no later than June 1, 1997.

(iii) *Form and content of notice.* A notice provided pursuant to this paragraph (e)(3) must be in writing and must include information substantially similar to the information included in a model notice authorized by the Secretary. Copies of the model notice are available at the following website—http://www.irs.ustreas.gov (or call (202) 622–4695).

(iv) *Providing certificate after request.* If an individual requests a certificate following receipt of the notice, the certificate must be provided at the time of the request as set forth in §54.9801–5T(a)(2)(iii).

(v) *Other certification rules apply.* The rules set forth in §54.9801–5T(a)(4)(i) (method of delivery) and 54.9801–5T(a)(1) (entities required to provide a certificate) apply with respect to the provision of the notice.

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